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ABSTRACT

Testimony is presented regarding the Education of the Handicapped Amendments of 1986 which mandates special education for handicapped children from the age of 3 and proposes a discretionary program of infant intervention. Testimony from the following agencies and associations is included: National Association of State Boards of Education; National Center for Clinical Infant Programs; Alexander Graham Bell Association for the Deaf; Consortium for Citizens with Developmental Disabilities; United Cerebral Palsy Associations, Inc.; American Speech-Language-Hearing Association; Epilespy Foundation of America; House Select Committee on Children, Youth and Families; National Association of State Directors of Special Education; National School Boards Association; Association for Retarded Citizens; American Association of School Administrators; National Governors Association; National Indian School Boards Association; American Federation of Teachers; National Conference on State Legislatures; National Society for Children and Adults with Autism; Council for Exceptional Children; Federation for Children with Special Needs; American Rehabilitation Counseling Association; American School Counselor Association; National Association of Elementary School Principals; American Rehabilitation Counseling Association; American Mental Health Counselors Association; National Council on the Handicapped; National Association of Secondary School Principals; National Education Association; United States Department of Education; and National Network of Parent Centers. (CB)

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THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

ON

S. 2294

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

HEARINGS HELD IN WASHINGTON, DC, JULY 23, 24, AND 29, 1986

Serial No. 99-120

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THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

WEDNESDAY, JULY 23, 1986

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to call, at 10:18 a.m., in room 2261, Rayburn House Office Building, Hon. Pat Williams (chairman of the subcommittee) presiding.

Members present: Representatives Williams, Hayes, Biaggi, and Bartlett.

Staff present: S. Gray Garwood, staff director; Robert Silverstein, majority counsel; Colleen Thompson, clerk; and David Esquith, minority legislative associate

Mr. Williams. I will call the meeting of the Subcommittee on Select Education to order.

Recently our colleague in the Senate, Lowell Weicker, introduced S. 2294, which reauthorizes the discretionary programs contained in the Education of the Handicapped Act. The legislation also amends part B of the Act to make the provision of special education and related services mandatory for all eligible children age 3 through 5. In addition, Senator Weicker has proposed a discretionary program of infant intervention.

We commend the Senator and the Senate for his and for their work. They have made a significant contribution to all of our efforts to provide appropriate education and related services to young handicapped children and infants.

I want to make it clear that I am a strong advocate of early intervention, and there is no doubt in my mind that it is the logical next step in our collective efforts to assist those who are disabled.

So, if we do early intervention it is not of concern, at least to this chairman. The questions, rather, are how we do it and when we do it. S. 2294 focuses our attention on the issue of course of early intervention, and I will bet that no one here today would argue when we say that early intervention is good social, as well as economic policy. It adds to the quality of human life, and it is cost effective for society.

As many of you know, the median cost of providing special education services to infants and preschoolers, as revealed in several studies, is approximately $2,100 per child. The cost for older children are more than double, or about $4,445 per child.

Put another way, based on data from 940 children enrolled in early intervention, only 243, or 26 percent would remain in special education if intervention were to begin in very early childhood. But if such intervention doesn't begin until the normal school years, 630, or 67 percent would very likely remain in special education.

Thus, to delay the onset of early intervention services can be costly in terms of human potential, and dollars. Early intervention with infants, toddlers and pre-schoolers is an intervention that effects the course of cognitive social and physical development. But early intervention also reaches beyond the child, to touch parents and siblings, our communities, our education institutions and society itself.

In short, we need to do it right the first time.

So, we have asked all of you here to help us with the how and the when, so that we can get it right the first time. Your views will be instrumental in shaping the answers to these very important questions.

My colleague, the ranking minority member, Mr. Bartlett.

Mr. **BARTLETT**. Thank you, Mr. Chairman.

It is my hope that the 3 days of hearings scheduled by the Subcommittee on Select Education on Senate bill 2294, the Education of the Handicapped Amendments of 1986, will be informative and constructive.

I want to commend Chairman Williams for extending invitations to a wide range of interested parties, considering the broad reach of this bill and its potential impact on our educational systems, it is imperative that every one affected be afforded the opportunity to comment on the proposal, both at these hearings, and subsequently. Now, these hearings are not on the subject, I think, of the effectiveness of early intervention on children with handicaps. I believe a sufficient record has been established that early intervention is both effective and desirable.

The question that we are confronting in these hearings is, How does the Federal Government proceed toward the goal of providing appropriate early intervention services to children with handicaps? S. 2294 proposes to answer this question according to certain policy assumptions, requirements, and procedures.

While it is a good starting point, I believe that S. 2294 may require a great deal of revision, in order to be acceptable. I look forward to our witnesses' recommendations for improving S. 2294. Considering the nature of the task, and the little time that remains in this session of the 99th Congress, I hope that all interested parties will recognize that in order to proceed we must be able to reach a consensus.

There is no doubt in my mind that such a consensus can be obtained and that the opportunity to improve early intervention services for handicapped children can be developed. When a proposal can be developed which improves early intervention services to handicapped children without inappropriately burdening State and local education agencies, over overextending the role of the Federal Government, then that proposal will have my complete support.

Thank you, Mr. Chairman.

Mr. **WILLIAMS**. Thank you, Mr. Bartlett.

Mario Biaggi has been a leader in this Congress for many years in helping the disabled and handicapped, and we appreciate his leadership in this legislation as well.

Mr. Biaggi.

Mr. **Biaggi**. Thank you very much, Mr. Chairman.

The issue of early intervention services for infants and children with handicaps is one of major concern and importance to me. I was one of the original authors of Public Law 94-142, and I have taken a personal interest in the success and effectiveness of education programs for children with disabilities. It has been my observation that these programs work, and do so, in large measure, to the strong leadership role displayed by the Federal Government.

It is obvious that this role must continue, if we are to provide effective early intervention services. Over 100 studies have been conducted in the efficacy of early intervention and 2 major conclusions were reached. The majority of children who participate in early intervention programs, regardless of the severity of their impairment, make educationally significant developmental progress. Clearly, such progress is at the very core, the intent and purpose of early intervention services.

The earlier intervention begins, the more intense the intervention and the longer intervention is provided, the greater are the benefits to both children and their families. The economic benefits derived from this process are astounding. For example, cost-effective data conclude that the average cost per child for special education services, age 6 to 18, for children nonparticipating versus participating in early intervention, is 27 percent higher each year.

An estimated 200,000 children with handicaps enter first grade each year. If half of these children participated in early intervention programs, the 27 percent savings would translate into a savings of $100 million annually.

I look forward with great anticipation to the testimony provided this morning, and subsequent hearings on S. 2294. It is an important and quite complicated bill, and one that certainly benefits from the input, comments and suggestions of all. It is my hope that we can work together, in order to improve and clarify this bill.

I firmly believe that legislative action in this area is needed, and these hearings will provide great insight and understanding to the many issues surrounding early intervention.

I want to thank you, and commend you, Mr. Chairman, for having these hearings. I look forward to the testimony.

Clearly, the longer we wait to pursue such services, the more detrimental to the thousands of infants and children with handicaps who are in desperate need of early intervention.

Mr. **Williams**. Thank you, Mr. Biaggi.

Mr. Hayes.

Mr. **Hayes**. Thank you, Mr. Chairman.

I just want to commend you for calling the hearing on this important matter. As a member of the Subcommittee on Select Education, I certainly view the question and the issue of education as so very important across all lines. We should do what we can to improve educational opportunities for all members of our society who desire it, including the handicapped.

I don't have a statement, except I think we ought to hear the witnesses. I notice we just got the call for a vote, as I expected. I will just sit in on the hearing and be a part of it, as much as I can for the next 3 days.

Mr. **Williams**. Thank you very much.

We appreciate your good participation in this hearing, as we have in so many of the others.

The bells have rung for our first vote this morning. Our first panel may wish to assemble in our absence, we will return quickly.

The first panel is Barbara Hanft, Tom Vickers, Fred Weintraub and Frank New. If they wish to come to the table, we will return shortly.

[Recess.]

Mr. **Williams**. Our first witness will be Barbara Hanft. Ms. Hanft is with the Occupational Therapy Association, and is representing the Consortium for Citizens with Developmental Disabilities.

It is nice to see you here today, please proceed. I will tell all of the witnesses that we have several days of hearings scheduled and a good many people want to testify. We are trying to accommodate as many as possible, but it does mean that each of you must attempt to stay within the time limit which we mentioned to you, when we invited you here to testify.

Ms. Hanft, it is good to see you here today, and please proceed.

STATEMENT OF BARBARA HANFT, OCCUPATIONAL THERAPY ASSOCIATION, REPRESENTING THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Ms. **Hanft**. Thank you, Mr. Chairman, and members of the subcommittee, thank you for the opportunity to speak to you today about early intervention programs for infants and pre-schoolers with handicaps.

I am Barbara Hanft, from the American Occupational Therapy Association, and I am speaking on behalf of the Consortium for Citizens with Developmental Disabilities. CCDD is composed of over 40 national organizations representing lay and professional advocates, as well as individuals with disabilities and their families.

I personally have 14 years experience as an occupational therapist and counselor for families with children who have handicaps. This includes directing an infant intervention program and working extensively in public and private schools with children receiving special education and related services.

Our consortium commends you for recognizing the vital importance of early intervention. We enthusiastically support the concepts of S. 2294. Today we would like to focus on four areas of great importance to the early intervention provisions.

Our first area concerns the intended beneficiaries of the bill. Early intervention should extend individualized services to an infant and family unit for the purposes of facilitating the infant's development. While it is obvious that an infant who is delayed needs specialized services, it is imperative that the family also be supported and trained to help the child grown and develop.

We support the Senate report definition of developmental delay as "a significant delay in one or more areas of development such as speech/language, cognitive, motor, or social/emotional development." We recommend that this definition be used for children under 6 years of age, and particularly for children under 3 years.

We urge that eligibility provisions of the Senate bill be expanded to include infants who have a high probability of becoming developmentally delayed. We acknowledge that States must have guidelines regarding which groups are truly at risk for developing a disability. Research has begun to identify some of these groups, such as those with extremely low birth weight, or those with grades III and IV intra-periventricular hemorrhage. CCDD recommends that an interdisciplinary group of child developmental experts be directed to study this question further and provide appropriate guidance to the States.

Our second area of concern involves recognition of the vital role families play in early intervention. We recommend a minimum of 25 percent, or at least two, whichever is the greater number, parent/guardian representatives on the Early Intervention Council to ensure that parental perspectives are considered. Parents, as consumers, have hands-on expertise with children with handicaps.

In addition, each State should demonstrate there is a system in place and encourage active parental, public and professional participation in the development and implementation of the State plan, and in the application for Federal funds.

Our third interest centers around the issues of administration and governance of the early intervention program. CCDD believes that effective early intervention requires the services of a variety of public and private nonprofit agencies. Most infants with developmental delays need a broad range of services that cut across many disciplines.

It is important that these services be provided by qualified personnel. We believe interagency coordination is essential in implementing this act, and the Early Intervention Council offers a primary vehicle for developing cooperative relationships. It is unreasonable to expect a single agency to furnish all the expertise and shoulder all the responsibility for providing early intervention services.

We do, however, recognize and support the concept of a lead agency to administer, supervise, and monitor these comprehensive services.

The mission of the Early Intervention Council should involve clear authority to develop, not just promote, interagency agreements. It should also strive to maximize utilization of all existing facilities and programs that have expertise in early intervention. We believe it is crucial that the council have its own budget and staff, in order to function effectively.

Effective program administration also requires cooperative relationships among the lead agency, State educational agency, and Early Intervention Council, particularly with respect to the State plan for early childhood education. The early childhood education plans now being developed by the State educational agencies under Public Law 91-199, and the State plan required in S. 2294, should be considered as a single unified working plan. This plan would provide for smooth transitions from a system serving birth through 2 years, to the State educational system at age 3.

To facilitate this cooperative relationship, it is necessary to include the State educational agency and each Early Intervention Council, and to require that the early intervention portion of the State plan be approved by the Early Intervention Council.

Transition planning should be the responsibility of all involved agencies, not just the State educational agency, or the lead agency.

Our fourth area of interest concerns the timelines and formulas for Federal financial assistance. CCDD supports a phase-in of services to allow unified planning for the statewide system of early intervention. This phase-in should be completed by September 1, 1990, which is the date States are now working toward in developing early education for children with handicaps under section 623 of EHA. Federal funds could be used in the planning and development process in those States which are not serving all infants with handicaps, or they could be used to supplement early intervention services currently being delivered. During this phase-in, Federal funds could be allocated using census data.

Services paid for by other sources, especially fees for health services and payments by insurers, must all be preserved and protected.

In closing, we urge you to act immediately on behalf of children with disabilities. Families need your leadership to provide comprehensive early intervention programs. They need it now. I can draw an analogy to my own son, who was born prematurely with circulatory problems. He received immediate care in an intensive care nursery, and thereafter was closely followed. Tomorrow is his first birthday, and I am pleased to report that he is healthy and thriving.

My son needed early intervention immediately and he received it. There are other children in need of early intervention, beyond the first days of life, who have not received services.

Thank you for the opportunity to address our concerns and interests, and I will be pleased to answer any questions you may have.

[The prepared statement of Barbara E. Hanft follows:]

ORAL STATEMENT

OF

THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

ON

S. 2294

EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

PRESENTED AT

HEARINGS BEFORE

SUBCOMMITTEE ON SELECT EDUCATION

U.S. HOUSE OF REPRESENTATIVES

BY

BARBARA E. HANFT, MA, OTR/L

JULY 23, 1986

Mister Chairman and members of the subcommittee, thank you for the opportunity to speak to you today about early intervention programs for infants and preschoolers with handicaps. I am Barbara Hanft from The American Occupational Therapy Association, Inc. (AOTA). I am speaking on behalf of the Consortium for Citizens with Developmental Disabilities. CCDD is composed of over 40 national organizations representing lay and professional advocates as well as individuals with disabilities and their families. I personally have 14 years experience as an occupational therapist and counselor for families with children with handicaps. This includes directing an Infant Intervention Program and working extensively in public and private schools with children receiving special education and related services.

Our Consortium commends you for recognizing the vital importance of early intervention. We enthusiastically support the concepts presented in S. 2294. Today we would like to focus on four areas of great importance to the early intervention provisions.

Our first area concerns the intended beneficiaries of the bill. Early intervention should extend individualized services to an infant and family unit for the purposes of facilitating the infant's development. While it is obvious that an infant who is delayed needs specialized services, it is imperative that the family also be supported and trained to help the child grow and develop.

We support the Senate Report definition of developmental delay as "a significant delay in one or more areas of development such as speech/language, cognitive, motor, or social/emotional development." We recommend that this definition be used for children under six years of age, and particularly for children under three years of age.

We urge that eligibility provisions of the Senate bill be expanded to include infants who have a high probability of becoming developmentally delayed. We acknowledge that states must have guidelines regarding which groups are truly at risk for developing a disability. Research has begun to identify some of these groups such as those with extremely low birth weight and those with grades III and IV intra-periventricular hemorrhage. CCDD recommends that an interdisciplinary group of child developmental experts be directed to study this question further and provide appropriate guidance to the states.

Our second area of concern involves recognition of the vital role families play in early intervention. We recommend a minimum of 25%, or at least two, (which ever is the greater number), parent/guardian representatives on the Early Intervention Council to insure that parental perspectives are considered. Parents as consumers, have "hands on" expertise with children with handicaps and therefore must be involved on the Council. In addition, each state should demonstrate that there is a system in place to encourage active public, professional, and parental participation in the development and implementation of the State Plan, and in the application for federal funds.

Our third interest centers around the issues of administration and governance of the early intervention program. CCDD believes that effective early intervention requires the services of a variety of public and private non-profit agencies. Most infants with developmental delays need a broad range of services that cut across many disciplines. It is important that these services be provided by qualified personnel.

We believe interagency coordination is essential in implementing this Act, and the Early Intervention Council offers a primary vehicle for developing cooperative relationships. It is unreasonable to expect a single agency to furnish all of the expertise and shoulder all of the responsibility for providing early intervention services. We do, however, recognize and support the concept of a lead agency to administer, supervise and monitor these comprehensive services.

The mission of the Early Intervention Council should involve clear authority to develop, not just promote, interagency agreements. It should also strive to maximize utilization of all existing facilities and programs that have expertise in early intervention. We believe it is crucial that the Council have its own budget and staff in order to function effectively.

Effective program administration also requires cooperative relationships among the lead agency, State Educational Agency, and Early Intervention Council, particularly with respect to the State Plan for Early Childhood Education. The Early Childhood Education plans now being developed by the State Educational Agencies under P.L. 98-199, and the State Plan required in S. 2294 should be considered as a single, unified working plan. This plan would provide for smooth transitions from a system serving birth through two years to the state educational system at age three.

To facilitate this cooperative relationship, it is necessary to include the State Educational Agency on each Early Intervention Council, and to require that the early intervention portion of the State Plan be approved by the Early Intervention Council. Transition planning should be the responsibility of all involved agencies, not just the State Educational Agency or the lead agency. The Early Intervention Council, because of its interagency membership, is in the best position to promote effective transitions from one system to another.

Our fourth area of interest concerns the timelines and formulas for federal financial assistance. CCDD supports a phase-in of services to allow unified planning for a state wide system of early intervention. This phase-in should be completed by September 1, 1990, which is the date states are now working towards in developing early education for children with handicaps under Section 623 of the EHA. Federal funds could be used in the planning and development process in those states which are not serving all infants with handicaps, or they could be used to supplement early intervention services currently being delivered. During this phase-in period, federal funds could be allocated using census data.

The ultimate goal for federal financial assistance should be to supplement other funding sources currently serving the birth through two year population. Services paid for by other sources, especially fees for health services and payments by insurers, must all be preserved and protected. However, all children, including the truly needy, must have access to early intervention services.

In closing, we urge you to act immediately on behalf of children with disabilities. Families need your leadership to provide comprehensive early intervention programs. They need it now. I can draw an analogy to my own son who was born premature with circulatory problems. He received immediate care in an intensive care nursery and thereafter was closely followed. Tomorrow is his first birthday and I am happy to report he is healthy and thriving.

My son needed "early intervention" immediately and received it. There are other children in need of intervention beyond the first days of life who have not received services. We urge you to pass legislation which acknowledges the great potential of early intervention.

Thank you for the opportunity to address our interests and concerns. I would be pleased to answer any questions you might have.

On behalf of:

American Association of University Affiliated Programs
American Association on Mental Deficiency
American Foundation for the Blind
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
ACLD, Inc., an organization for Children and Adults
  with Learning Disabilities
Association for Retarded Citizens of the United States
Disability Rights Education and Defense Fund
Epilepsy Foundation of America
National Association of Developmental Disabilities Councils
National Association of Protection and Advocacy Systems
National Easter Seal Society
National Mental Health Association
National Recreation and Park Association
National Society for Children and Adults with Autism
The Association for Persons with Severe Handicaps
United Cerebral Palsy Associations, Inc.

Consortium for
Citizens with
Developmental
Disabilities

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The following members of the Education Task Force of the Consortium for Citizens with Developmental Disabilities wish to thank the Subcommittee for holding hearings on the early childhood initiatives incorporated in S. 2294. We want to reiterate our strong support of these federal initiatives and with the following recommendations be considered along with our oral testimony.

Definition of Eligible Population and Nature of Programs

The Education Task Force recognizes the vital role that families play in early intervention and in establishing a system to provide such services. It has been our experience as a consortium composed of professionals, service providers, consumers and family members of individuals with disabilities that parents provide special expertise in how services should be provided. We ask that the Committee focus on the fact that successful early intervention services are not only centered on the child, but are also focused on the interaction between the child and his/her family.

Therefore, the definition of early intervention should be expanded to more accurately reflect the precise nature of the program. We suggest the following definition:

> Early intervention should provide for each infant with a handicapping condition individualized services designed to reduce or ameliorate the effects of the handicapping condition. The program shall include appropriate family services and parent training. Such services shall be provided in the home and/or in community based centers. Program services shall be provided on a full year basis, when appropriate.

Regarding what constitutes a handicapping condition for the purposes of this bill, we recommend the following:

o The term "developmentally delayed" should be used as the only label in defining the handicapping conditions for all children under six years of age. It is particularly inappropriate to label infants when the etiology and extent of their delay or disability is only beginning to manifest itself.

o The Senate Report definition of developmental delay should be retained. However, the term "substantially" should be deleted from the definition of handicapped infant contained in S. 2294. It is inappropriate to attempt to define how delayed or disabled an infant is when standardized evaluation tools are unavailable to yield such precise scores.

o The definition of "handicapped infant" should be expanded to include infants who have a high probability of becoming developmentally delayed. Without this expansion states that are now appropriately serving these at-risk children may be deterred from doing so. Research thus far has identified some of these groups such as those with extremely low birth weight and those with grades III and IV intra-periventricular hemorrhage.

In order to better determine what constitutes an at-risk condition, we recommend that an interdisciplinary group of child developmental experts be directed to conduct a study on this issue.

Nature of the Early Intervention Program, 0-2 Years/Personnel/Due Process

Early intervention services should include a broad array of health, education, and social services needed by the family of an infant who is developmentally delayed. These services should be delineated in the individualized program.

Each individualized program plan (IPP) should address services needed by the infant and his family as well the agency responsible for delivering the services. Support to parents in the form of counseling and respite services, as well as specific training to work with the infant, as appropriate, are as important as defining what specific services the infant requires.

Each IPP should be reviewed at least two times per year, once by the multidisciplinary team that conducted the initial evaluation and once by the team members who have been most involved in delivery of services. Between the ages of two to three, the IPP must plan for transition to school based services, or other community services if the P.L. 94-142 mandate is not extended to include children three through five years.

Regarding the "ability-to-pay" provision, CCDD recommends that federal funds from this act be used only as the payer of last resort. The ultimate goal of federal financial assistance should be to supplement other funding sources currently serving the birth through two year population. In addition, services paid for by other sources, especially fees for health services and payments by insurers, must be preserved and protected. This should not preclude any child from receiving needed services.

CCDD believes that early intervention services should be provided by qualified personnel who have had experience and training regarding infants with developmental delay as well as parental needs and concerns. We acknowledge that it is very difficult to legislate this type of experience. Therefore, we recommend that, at a minimum, personnel be trained and hold licenses or certification appropriate to their profession. Such provisions require entry-level competency only. This must be the minimum acceptable standard for working with the complex needs of infants with developmental delay. We, therefore, offer the following definition of "qualified":

> Individuals who have met state established education and training standards for obtaining a license/registration to practice the profession in the state, or in the absence of such standards, have met professionally recognized standards developed by the national certification board in the appropriate profession. In the absence of licensure, registration, or national professional standards, the individual shall meet the highest standard appropriate to the professional area in which he/she is providing special education or related services.

We urge that a due process provision be included in the legislation protecting the rights of parents and their children. We support the due process concept in S.2294. However, we recommend that (1) the statute should clearly set forth agency responsiblities for due process procedures. (We suggest that the due process procedure be initiated within the agency with jurisdiction over the specific problem), and (2) the due process provisions should include attorneys fees.

Governance of the 0-2 Program/Early Intervention Council

CCDD strongly believes that inter-agency coordination is essential in implementing the early intervention program for infants with handicaps to serve children between birth through two years of age. Legislation authorizing such a program should require a single lead state agency, designated by the governor of each state, which would be responsible for administering the program.

Effective early intervention requires the involvement of numerous public and private agencies at the state and local levels. Most infants with developmental delays need a broad range of services that cut across agencies and professional disciplines. We recognize that it is unreasonable to expect a single agency to furnish all the expertise and shoulder all of the responsibility for providing early intervention services. We support the concept that a lead state agency administer, supervise and monitor the comprehensive services needed to meet these diversified needs of the infants and families.

The primary responsibilities of the lead agency, should be, developing, in concert with the Early Intervention Council, the state plan and application; developing standards, licensing programs and other criteria for funding services; and, maximizing inter-agency cooperation at the state and local levels.

CCDD strongly endorses the Early Intervention Council as a vital component of an early intervention program. This council should be comprised of state agency representatives, state and local early intervention service providers, child and family advocates and other experts as designated by the governor. The State Education Agency must be a member of the Council. We recommend that a minimum of 25% (or a minimum of two individuals, whichever is the greater number) of the Council be parents and/or guardians of infants with disabilities. The expertise and "hands on" experiences of such parents and guardians would be invaluable to an effective Council. The governor could select such parents/guardians from a list provided by the state Developmental Disabilities Council. The governor should also appoint a Council chairman from among the membership.

The Council should have several mandated responsibilities, the most important being 1) the development and approval of a comprehensive early childhood plan and application and 2) the development of inter-agency agreements to maximize fiscal resources as well as facilities, programs and professional expertise. Other duties as specified in S. 2294 are also appropriate.

Legislation should seek a careful balance between the Council and the lead state agency. Clearly, the lead state agency should be represented on the Council. The lead state agency and the Council should play joint roles in the development of the early intervention state plan and application for federal financial assistance. The Council should approve the plan and application prior to its submittal to the Governor and the federal government (Department of Education).

The Council should have its own staff and budget, separate from that of the lead state agency to guarantee independence and effectiveness. Congress should set a minimum allocation for the operation of the Council and the state should be asked to participate in the funding. There should also be a cap on the amount of administrative costs that the Council could claim from the federal funds appropriated to conduct the Early Intervention Program.

The Early Intervention Program should be a state program, but one which maximizes the use of service providers at the local level via contracts or other financial arrangements. The program should also be statewide, and the state plan should contain assurances of regional comparability.

Administrative costs should be available to both the lead state agency and the council. The statute should define these costs for each group and set forth maximum levels.

We recommend that the application procedure contained in Section 627 include the comprehensive early childhood state plan for services to children with disabilities from birth to age five as an integral part of the state's application. The Early Childhood Education plans now being developed by the State Educational Agencies under P.L. 98-199, and the State Plan required in S. 2294 should be considered as a single, unified working plan. This plan would provide for smooth transitions from a system serving birth through two years to the state educational system at age three. The plan and application should contain maximum specificity to demonstrate the steps the state will take to meet the statute's implementation timelines.

Each state should demonstrate that it has a system in place to encourage and receive active public, professional and parental participation in the development and implementation of the state plan and in the application for federal funds. Language such as that contained in H.R. 4021, Section 101(a)(23)(A) as passed by the House might be utilized.

Timelines

Regarding the timelines and formulas for federal financial assistance, CCDD supports a phase-in of services to allow unified planning for a state wide system of early intervention. This phase-in should be completed by September 1, 1990, which is the date states are now working towards in developing early education for children with handicaps under Section 623 of the EHA. Federal funds could be used in the planning and development process in those states which are not serving all infants with handicaps, or they could be used to supplement early intervention services currently being delivered. During this phase-in period, federal funds could be allocated using census data.

The ultimate goal for federal financial assistance should be to supplement other funding sources currently serving the birth through two year population. Services paid for by other sources, especially fees for health services and payments by insurers, must all be preserved and protected. However, all children, including the truly needy, must have access to early intervention services.

Three Through Five Mandate

The Congress has been providing funding incentives to the states for early childhood services for the past ten years. This funding has allowed states maximum flexibility in determining how funds they accept are to be used. The designers of these federal funds hoped that the initiatives would be used to demonstrate successful early childhood models that would lead to quality early childhood services in the states to all infants in need of intervention and pre-school. To date, half of the states have chosen not to provide services for the three through five year old population. It is becoming clear that without a federal mandate, appropriate quality services will not be provided in all of the states. We have seen enough successes in states that have adopted a state mandate to know that a federal mandate can work. The Education Task Force strongly supports the adoption of the mandate embodied in S. 2294 as a part of the current Part B requirements for school age children.

We support additional funds earmarked for this population during the phase-in period, after which these additional funds should be folded-into the P.L. 94-142 "pot."

In determining the population to be served the Task Force urges the adoption of the noncategorical classification found in S. 2294. The term developmentally delayed identifies a child as needing special educational/developmental services without attaching to that child a more damaging label that will likely follow him/her for many years.

As has been pointed out to this Subcommittee numerous times during the three days of hearings just completed on the provisions of S. 2294, there is no doubt that early intervention services are cost efficient. Many studies were cited reflecting substantial savings. While we believe this is reason enough to pass this bill, we wish to emphasize that this issue has broader implications: that is the federal government's moral obligation to adopt a national policy extending services to infants and young children with handicapping conditions.

The inconsistencies in state programs place undue burdens on parents of infants and young children with handicapping conditions. These families are often faced with difficult decisions affecting their stability. Basic decisions such as where to reside became intricately influenced by their child's handicap. It is clear that the federal government must take a leadership role to guarantee quality programs nationwide.

An Association for Children and Adults with Learning Disabilities

American Association of University Affiliated Programs

American Foundation for the Blind

American Occupational Therapy Association

American Physical Therapy Association

American Speech-Language-Hearing Association

Association for Retarded Citizens

Epilepsy Foundation of America

National Easter Seal Society

National Society for Children and Adults with Autism

United Cerebral Palsy Association

The Association for Persons with Severe Handicaps

National Association of Developmental Disability Councils

Mr. **Williams**. Thank you, Ms. Hanft.

We will go ahead with the rest of the panel, and then have questions following the last witness.

Our next witness is Senator Tom Vickers. Senator Vickers serves in the State senate in the State of Nebraska, and is here representing the National Conference of State Legislatures.

It is nice to have you with us, Senator.

Senator **Vickers**. Thank you, Mr. Chairman.

STATEMENT OF SENATOR TOM VICKERS, STATE SENATOR, STATE OF NEBRASKA, REPRESENTING THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Senator **Vickers**. Mr. Chairman, members of the committee, my name is Tom Vickers from Nebraska, and I appreciate the opportunity to be here before you representing the National Conference of State Legislatures.

I was the chairman of a special committee in Nebraska, to examine the issue of early childhood special education, since we have had early childhood special education from the date of earliest diagnosis, or birth since 1978 in Nebraska. So, perhaps, our experience will be helpful to you as you develop your legislation. You have copies of the interim study distributed to you. I would encourage you to examine them, at least the green pages that indicate the findings that we have attempted to implement.

Let me begin by saying that it is a matter of policy the State legislatures of the country and the national State legislatures are official representative organizations and have long supported the national commitment to provide an appropriate education for handicapped children. We applaude the progress that has been made in protecting the due process rights of handicapped children, which has assisted the States and the Federal Government in providing and funding expanded programs to serve these children.

Recent studies indicate that many States have moved ahead of the Federal Government in their special education efforts and requirements. While this is laudable, it is clear that much still needs to be done, and it should be done with the full support and cooperation of the Federal Government as a matter of national interest.

It would be an understatement to say that times have changed. Over the past 10 years, or so, it is the States that have taken a noticeable lead in providing new and expanded services to handicapped children. According to recent reports, most States are doing more than current Federal law requires and many of them are doing more than this legislation would propose.

In a report issued by the Congressional Research Service in March of this year, entitled Preschool Programs for the Education of Handicapped Children: Background, Issues, and Federal Policy Options, a school year 1984-85 survey completed by the U.S. Department of Education's Office of Special Education was cited that found of the 50 States, 39 mandated services to some portion of the handicapped population from birth to age 5, with 10 of them providing services from birth to 2, inclusive, and 20 providing some services for children age 3 and under.

I would like to draw your attention to the word "some," it is some services, not all services by many of these States.

I would also like to urge you, as you develop this legislation, to be cognizant of definitions or the criteria of handicapped conditions for preschool children, because those definitions across the country are varied. We definitely found that out in Nebraska, even between school districts. That was one of our concerns, that as children move from one location to another, that they would receive the appropriate services in any location. I would assume this would also be between States, as well.

So, issues such as definition and need of services appropriate to meet that need are especially important when it involves the service delivered to the birth through age 2 population. We did find out that that population that needs services are difficult to identify. The portion of the population needing those services are more expensive and in Nebraska our cost for preschool programs right now is about $4,900 per child.

Part of the reason for that is because the diagnosis are becoming increasingly better, we have learned over the years how to diagnose the problems. There is a definite cost-benefit by treating them, we believe, at that age, but you should be aware of the fact that it is going to cost considerable amounts of money.

The other thing that we discovered, that I want to caution you on, is especially in some of the more rural areas—and Nebraska, as you know, is pretty rural—the demand for related services for infants, or for preschool children. A lot of those services are physical services and the numbers of occupational therapists, physical therapists, those kinds of medically-related providers are not always available in many of the areas.

So there has to be a considerable amount of coordination and cooperation in order to be able to provide these services.

In Nebraska we found that the number of children being served has increased dramatically since 1978. Again, as I indicated, I think it is because of the diagnostic ability, as well as medical science. We have found out that medical science has been able to save a lot of children that previously weren't saved, and the schools are having to deal with them. Our increase since 1978, in number of students served has been 168 percent, in the 0 to 5 age group. Our teachers now work with children who each display a greater number of handicaps, multi-handicapped are the ones that are growing the most, as you will find in that handout.

The other point that I would like to bring to your attention is the concern that we have about the coordination, the Early Intervention Council is a good idea. Because State legislatures are very much involved in study the policy and appropriating the resources for the programs serving the handicapped children, I would recommend that a State Early Intervention Council include one member from each house of the State legislature. Of course, in Nebraska, that would be only one house—selected by the presiding officer. And that an annual report issued by such a council be submitted to legislature, as well as to the Governor.

We believe that such a change, in S. 2294, would assure that all of the major actors at the State level were included in the information loop.

We would be remiss if we didn't talk about the subject of cost. As I mentioned previously, it should be recognized that the increase in fiscal support for special education for students of school age was predicated on the achievement of equity and equal protection under the law. The same circumstances are not necessarily in place for the preschool age group. Also the fact, as I mentioned, that costs can grow considerably. A number of the States, including Nebraska, are experiencing very severe fiscal situations with the agricultural situation, the energy crisis. In the handout that I gave to you, it includes a number of States—we are contemplating in Nebraska whether or not we may have to have a special session because of our economic situation.

So, we would hope that as the Federal Government moves into this area, given the current economic conditions, that they would at least give the States a few years to phase-in to that program, because of that cost, unless the Federal funds were going to be provided. We recognize that you have some problems there, as well, with the devaluation and the problems that we are having in a number of the States.

In Nebraska, in particular, if we did not already have the program, it is doubtful that we would be able to provide the funds to do it. Just to give you some figures, as I mentioned, the cost right now per person is about $4,900 per child, on average in the preschool programs. Our programs for the school aged handicapped children in Nebraska consumes about 12.85 percent of our total educational budget. So, again, you can see that we are faced with some difficult decisions, in terms of priorities.

I would simply conclude by letting you know that the results of the study—a number of those findings were adopted by the recently concluded session of the Nebraska Legislature. We have made a commitment to continue the providing of services from birth, and we have developed this program since 1978, to serve a number of people. We would encourage you, as you set your definitions and criteria, that you consider those States who have already moved in that direction, so that those criteria will not cause us to have to change our criteria.

Finally, since I serve on the same side of the table occasionally as you do in some of these situations, I would encourage you as you mandate programs to try to get some of the funds down to us as well, because we are having difficult problems.

It might be better, instead of mandating, to put in some mechanisms to encourage the schools and the States to do it without such a strong mandate, or at least if a mandate is there, that you are careful, that it doesn't upset it for some of us who have already done it.

Again, I thank you for the opportunity to appear before you. I will be happy to answer any questions you may have on the subject.

[The prepared statement of Hon. Thomas Vickers follows:]

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TESTIMONY OF

SENATOR THOMAS VICKERS

NEBRASKA LEGISLATURE

ON BEHALF OF

THE NATIONAL CONFERENCE OF STATE LEGISLATURES

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ON THE SUBJECT OF

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

JULY 23, 1986

TESTIMONY OF SENATOR THOMAS VICKERS, CHAIRMAN OF THE EDUCATION COMMITTEE, NEBRASKA LEGISLATURE, BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION, U.S. HOUSE OF REPRESENTATIVES, ON THE SUBJECT OF THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986. PRESENTED JULY 23, 1986, IN WASHINGTON, D.C.

Good morning. I am Senator Thomas Vickers, chairman of the Committee on Education in the Nebraska Unicameral Legislature, and recently chairman of the Select Committee on Services to Children Under Age 5 and Their Families. I am pleased to appear here today on behalf of the National Conference of State Legislatures to present testimony on a very important piece of legislation, the Education of the Handicapped Amendments of 1986.

Let me begin by saying that, as a matter of policy, the state legislatures of the country and the National Conference of State Legislatures, their official representative organization, have long supported the national commitment to provide an appropriate education for handicapped children. We applaud the progress that has been made in protecting the due process rights of handicapped children, which has assisted state and federal governments in providing and funding expanded programs to serve these children.

Recent studies indicate that many states have moved ahead of the federal government in their special education efforts and requirements. While this is laudable, it is clear that much still needs to be done and it should be done with the full support and cooperation of the federal government as a matter of national interest.

It would be an understatement to say that times have changed. Over the past 10 years, or so, it is the states that have taken a noticeable lead in providing new and expanded services to handicapped children. According to recent reports, most states are doing more than current federal law requires and many of them are doing more than this legislation would propose.

In a report issued by the Congressional Research Service (CRS) in March of this year entitled Preschool Programs for the Education of Handicapped Children: Background, Issues, and Federal Policy Options, a school year 1984-85 survey completed by the U.S. Department of Education's Office of Special Education was cited that found of the 50 states, 39 mandated services to some portion of the handicapped population from birth to age 5, with ten of them providing services from birth to 2, inclusive, and 20 providing some services for children age 3 and under.

That same Seventh Annual Report of the Department of Education cited by CRS also notes activity in many states to:

> (1) develop early intervention legislation; (2) develop program standards and guides for early education teacher certification and training; (3) develop eligibility criteria for participation in early education programs; (4) collect program effectiveness data on early intervention; (5) improve preschool service delivery through interagency cooperation and coordination; and (6) achieve interagency coordination.

In addition, our information indicates that virtually every state in the nation has, within the last couple of years, begun developing plans to provide services to handicapped children from birth to age 3 within the next three to five years. It seems clear, therefore, that legislatures and other state officials have been and continue to be quite active in advancing the availability of services to handicapped children throughout the country without the imposition of new federal mandates.

Much has been said of state-federal partnerships in recent years, but that, in this case, is what we should be striving for: a commitment to a new partnership between the states and the federal government to make available the resources and the guidance necessary to provide educational and developmental services to handicapped children of all ages. We are not faced with a condition of recalcitrance across the nation as we are with a situation that begs such questions as "Who should get what services, and when?" and "How shall they be paid for, and by whom?"

Definitions of handicapping conditions for preschool children, especially infants, are varied. According to the CRS report, "The number of handicapped children nationwide who are not receiving preschool education and related services or lack appropriate services is a matter of speculation. Any reliable estimate would depend on a common definition for who needs services and what services are necessary: no such agreement exists among States or even among preschool intervention specialists." Perhaps an appropriate federal role would be to find a way to clarify a common definition for who needs services and indicate guidelines for appropriate services necessary to meet their needs. Such a clarification could prove to be of great benefit to states and localities in providing appropriate services to preschool handicapped children.

Issues such as definition of need and services appropriate to meet that need are especially problematical when it involves service delivery to the birth through age 2 population. CRS states that this is true because:

> (1) the population needing services is difficult to identify; (2) the proportion of the population needing more expensive, non-educational services is high; (3) services are likely to be necessary from a variety of disciplines and agencies; and (4) the appropriateness of a strictly education focus for these children may be open to question.

There is no doubt that a variety of agencies and funding sources will be needed to supply the program components necessary to serve infants. The real question is whether a child's needs are primarily medical or educational/developmental. It may be that sorting out which agency is to provide what service is the key to providing effective programs, which brings me to the issue of the proposed state Early Intervention Council.

As a practical matter, such an entity may provide the coordination necessary to cut through territorial boundaries, as long as some flexibility is left to the states to determine the nature and location of such a council. No state official, including myself, likes to think about having yet another entity to deal with. But such a council, should something like it not already exist in a state, could help to coordinate service delivery and funding between agencies in a way that may not now be evident. However, I would suggest that, should you chose to retain this requirement in the legislation, you alter Section 624 in S.2294 to better acknowledge the differences in state procedures for bringing it about by changing the language in (b)(1)(A) to read, "Subject to the provisions of subparagraph (B), each State shall establish or designate a State agency. . . In carrying out this paragraph, each State may designate the State educational agency. . ." Also, further on in (b)(1)(B), following "Education of the Handicapped Amendments of 1986," as a matter of continuity with the above we would recommend the wording "that agency shall be designated for the purpose of administering this subpart. . ." Such wording would take into consideration not only individual political differences between the states and the concept of separation of powers, but the very real possibility that such a designation may occur in state implementing legislation.

Also, because state legislatures are very much involved in setting the policy and appropriating the resources for programs serving handicapped children, I would recommend that a state Early Intervention Council include one member from each house of the state legislature selected by the presiding officer, and that annual reports issued by such a council be submitted to the legislature as well as to the governor. Such a change in S.2294 would assure that all the major actors at the state level were included in the information loop.

It is possible that such a council might serve the national interest at the federal level, as well. Inasmuch as many funding sources beyond P.L. 94-142 would be involved in increasing services to handicapped preschool children, a federal coordinating body might go a long way toward cutting through the confusion of services and programs available to the states, as well as to set an appropriate example for state and local action. We suggest this in all seriousness. As it stands, the complexity of sorting and coordinating services to the target population is on the backs of the states. There is nothing in this legislation to encourage federally provided services to be coordinated, and without coordination at the federal level, states run the risk of getting blamed for a lack of coordination that is beyond their control. Leadership for implementing programs of service to handicapped children should be at the state level, but coordination of federally-provided services to aid in that effort should be carried out in Washington, D.C.

We would be remiss if, at this point, the subject of cost was not mentioned. It should be recognized that the tremendous increase in fiscal support for special education for students of school age was predicated on the achievement of equity and equal protection under the law. While the concepts are worthy and may be popular, the same circumstances are not present to encourage state expenditures for preschool programs. States and school districts do not commonly or universally make education available to children of less than five years of age. Rather, expansion is justified by the unusual learning needs of the handicapped children we are seeking to serve. Therefore, the federal share of the funding will need to reach beyond the token 7 to 10 percent currently appropriated, if indeed education of the handicapped is in the national interest and the state-federal partnership is to work.

The U.S. Department of Education's report previously cited by me and the CRS concluded that a constraint on states to require early educational services to handicapped children is limited fiscal resources. CRS reports that "Barbara Smith, writing on the federal role in expanding service to young handicapped children, contends that insufficient fiscal support has resulted in States not serving some children even if mandated to do so, and that this situation is likely to get worse in times of Federal, State, and local budget cutbacks."

We are aware of the fiscal plight of the federal government, a plight that may be the result of its own priority-setting, but I should remind you that there are a number of states in fiscal distress, as well. Conditions in the agricultural sector and the radical reversals in the energy market have many states in the heart of our nation gasping. (According to an as yet incomplete NCSL annual fiscal survey, over a dozen states are projecting zero balances or deficits for FY 1987, including Montana, Texas, Pennsylvania, and Vermont.) This is in addition to the reported fact that the recent economic recovery has not been even throughout the economy. Also, while devaluation and low inflation is evident in the manufacturing sector, inflation still is quite prevalent in the service sector. Education is a service sector industry and the costs of providing those services continues to rise. In Nebraska alone, educational services to preschool handicapped children is approaching $4,900 per child on average. Our programs for school-age handicapped children consumes some 12.85 percent of our instructional budget. Given current economic conditions, it is doubtful that we could soon take on the burden of a new, expensive federal mandate, if we did not already have those services in place. Therefore, we strongly recommend a 4 to 5 year phase-in for any new service expansion requirement.

The National Conference of State Legislatures believes that providing resources to help the states serve special-needs populations is a legitimate federal role in education and is in the national interest. Therefore, we heartily agree with the report from the Commission on the Financing of a Free and Appropriate Education for Special Needs Children to this Subcommittee in March, 1983, in which it said,

> Several studies of the implementation of P.L. 94-142 in states and local school districts have documented the inadequacy of Federal support for handicapped education. The Commission also found that practitioners across the country cite inadequate funding as one of their major problems. In fact, since the passage of P.L. 94-142, the Federal portion of the excess cost of special education has dramatically declined, despite an overall increase in appropriations. . . Accordingly, the Commission recommends that Congress appropriate sufficient additional funds to the P.L. 94-142, Part B program to bring the Federal share of excess costs close to the 40 percent originally stated in the law. The Commission believes that until the cost of educating handicapped children is spread more equitably across all governmental levels, the Federal government will not be fulfilling its responsibilities for the education of handicapped children.

On behalf of the National Conference of State Legislatures, I appreciated the opportunity to meet with you today and offer our continued assistance in helping to serve handicapped children throughout the country.

Mr. **Williams**. Thank you, Senator.

Our next witness is Fred Weintraub. Mr. Weintraub is the Assistant Executive Director, Council for Exceptional Children.

Fred, it is nice to see you again, please proceed.

STATEMENT OF FREDERICK WEINTRAUB, ASSISTANT EXECUTIVE DIRECTOR, COUNCIL FOR EXCEPTIONAL CHILDREN, REPRESENTING THE COUNCIL FOR EXCEPTIONAL CHILDREN

Mr. **Weintraub**. Thank you, Mr. Chairman.

As you noted, I am Fred Weintraub, Assistant Executive Director of the Council for Exceptional Children. I would like to mention to you that accompanying me today, to assist in responding to any questions you may have is Dr. Barbara Smith, who as you know is one of the leading authorities in early childhood programs for handicapped children across the country.

I would request that the complete text of our testimony be included in the record, and we will attempt to summarize the remarks.

The Council for Exceptional Children is pleased to have this opportunity to convey our views respecting S. 2294, the Education of the Handicapped Amendments of 1986.

In that spirit, Mr. Chairman, we appreciate your action in holding these hearings, we know that your time table did not call for the reauthorization of this Act this year, and we are pleased with your response to convening at least three days of hearings.

CEC strongly supports the basic objectives and the basic construct of S. 2294, respecting early intervention and preschool education for handicapped children ages birth through 5 years. However, after considerable deliberation with our members in the field, the CEC has concluded that S. 2294 inadequately addresses the critical issues in the reauthorization of EHA beyond the early childhood issues. In that context, we would observe that your subcommittee staff and other House staff have been making both an intensive and comprehensive study of the overall EHA in relation to current and future issues and needs. Areas that still require attention and action include, but are not limited to, personnel training, technology, data collection, under-represented populations, recruitment and transition services, et cetera.

While we believe that S. 2294 requires further refinement in the area of early intervention, we would recommend to you that you restrict your deliberations to the early childhood portions of 2294, work for final enactment of these provisions this year, and take up the overall reauthorization of EHA next year.

CEC believes that such a legislative schedule would allow a sensible timeframe for the preparation of sound legislation in both areas.

The objective of S. 2294 in the age range of 3 through 5 is straight forward, to provide to this age group the free appropriate public education as guaranteed to school aged children under the basic terms of Public Law 94-142. The Council for Exceptional Children has always sought this goal.

While we realize that there will be additional costs, as we suggest and outline in our statement, the Council for Exceptional Children believes that States, localities, and the profession are ready to meet this important challenge with Federal assistance.

We agree with the Senate in their addition of the term "developmentally delayed" to the existing definition for handicapped children in the 3 through 5 age category. We believe this to be an important step in overcoming problems of labeling children, and, in fact, we believe that the longstanding definition and data reporting requirements for handicapped children of school age in the Education of the Handicapped Children's Act should be re-examined with the same concern in mind.

We are concerned that for the age range in question, parents are a critical part of the instructional process, and that services under Public Law 94-142 should include, where appropriate, instruction for parents, so that they can be an active and knowledgeable member of the instructional team for their child.

The Senate bill designates 3 years from enactment as the effective date for guaranteeing the provisions of Public Law 94-142, to the 3 to 5 year old age group. We feel that it is important to have a specific date which can be read in the law itself, and to have a date which is consistent with the school year.

We recommend, as a number of others are, an effective date of September 1, 1990; such a date would be consistent with the finalization of the States of their participation in the planning process authorized under part C of the Education of the Handicapped Act.

In regard to funding of the 3 through 5 year old population, we would recommend that in the development phase, before the effective date of implementation, funding be continued through both the 94-142 and the preschool incentive grant program. During that period the States need maximum flexibility in the use of Federal fiscal resources and the ability to target resources to this population. These combined approaches would provide both flexibility and targeting capacity.

However, we would recommend a new formula for the preschool incentive, the current formula distributes money as a reimbursement, based upon the number of handicapped children 3 through 5 currently being served. Such an approach does not help States not currently serving children in the 3 to 5 age range.

We recommend that for the additional dollars appropriated above the current appropriation for preschool incentive program, that the census approach be utilized, that is, each State's relative population of children ages 3 through 5.

Further, we would recommend that the Congress establish fixed authorization levels, instead of having the floating formula as contained in the present preschool incentive grant program.

At the effective date, when handicapped children ages 3 through 5 come under the legal umbrella of 94-142, we would recommend that funding for that age group should logically fall within the overall Public Law 94-142 formula, and consequent appropriations.

In our statement—I might repeat it at this point—we do want to emphasize the point that it is going to cost new dollars to do this, and that if, in the long run both the dollars for this and the dollars for the fundamental support of 94-142 do not reflect the needs, then inevitably the service to 3 to 5 year old children are going to come off the back of school aged children.

I think the field is willing to take that risk, however we have to depend upon you to assure that in the long run the dollars that we need are going to be there.

On the issue of children birth through 2, S. 2294 would create a new program for the provision of comprehensive services to handicapped children birth through 2 years of age. CEC supports the objectives and the basic construct of this portion of the legislation, but we believe that further refinement of the legislation must be provided by the House.

Discussions should continue regarding the definition of handicapped infants contained in the Senate bill, first from the standpoint of children at risk, the definition is wholly inadequate. CEC has consistently argued that the eligible population should be handicapped infants, and infants at risk of being handicapped.

Also, the failure to make provision for at-risk children at the Federal level may have a regressive effect in States which are now addressing the needs of that population.

Second, the Senate definition includes the term "substantially developmentally delayed," the use of the word "substantially" is inappropriate for this age group, suggesting as it does clinically demonstrable discrepancies which are simply not functional in the assessment of infants.

In stating when infants and their parents shall be eligible to receive what the Senate bills refers to as "the necessary services." We are uneasy respecting whether this is the best standard in the critical matter of determination of services, and we hope to explore this issue further with the House.

Similarly, attention should be given to the definition of early intervention. We would recommend, as we have done with the 3 to 5 population, an effective date of September 1, 1990, for the same reasons I previously noted.

Mr. Chairman, we do not have a reliable estimate of the annual cost of this program once it is fully implemented. Given the vast array of public and private agencies at all levels that would be participating, and given the fact that the size of the eligible population is still an open issue, producing cost estimates are difficult.

We would suggest that there clearly needs to be an authorization, and we believe that this should be on an escalating scale, and that the formula for the authorization should extend beyond the implementation date.

One of the problems for service providers is as we look at the Senate bill, it tells you what you need to do for 3 years to achieve the mandate, and then it doesn't tell you what the Federal support will be, once the mandate is in place. That is not very encouraging to people who are out in the business of trying to provide the services.

Mr. Chairman, this program will succeed only if it is successfully coordinates and utilizes resources at the Federal, State and local level beyond whatever resources are provided for this program itself. The EHA dollars provided for this early intervention program have got to be the dollars of "last resort" as applied, for instance, in the Head Start Program.

If the availability of this program ends up chasing other resources away, when exactly the opposite must occur, then we will have failed in this important mission for handicapped infants and infants at-risk. We cannot emphasize this concern too much. There exists a wide array of Federal, State, local and private resources presently available to serve handicapped and at-risk infants.

This bill presumes the continued availability of those resources. Our experience with Public Law 94-142 has been that nonschool based resources that previously served handicapped children were redirected elsewhere when the responsibility for these children's education fell on the schools. If this were to occur for infants, the result would be disastrous. Neither States, nor the Federal Government could afford to make up the difference. It is essential that every effort be made in this legislation to prevent this from occurring. I cannot emphasize that too much.

Finally, I would simply say in this regard that it is important for the Federal Government to take care of its own backyard. Many of the programs that we are going to be talking about, or that are involved in the delivery of the services to infants, are Federal programs. Some of the biggest offenders of what happened in 94-142 were other Federal programs that ran away.

We would call for the creation of a blue ribbon commission, or some other panel, to take a look at the States' implementation of this law and to look at the role of Federal programs, and to report back to the Congress, and to the Federal agencies on how the regulations and laws of these programs need to be changed, to assure that the services that they provided, can, in fact, be effectively used by the State.

Often what happens is that we criticize States and localities for their failure to have interagency agreements, when in many cases one of the reasons they don't have them is that the offending parties are, in fact, the Federal agencies.

I would make one other comment, and that is—and I will skip over the question on State planning—we would like to simply emphasize to you that this this bill addresses the question of the delivery system that may be necessary to assure the children receive the services.

There is a difference between having the system and having the system that is also capable of delivering quality services. We would hope that we can separate, for the purpose of the present discussion, those two issues. But it is very important and we need to remember that there are other programs, such as the Handicapped Children's Early Education Assistance Program, which has been in existence, and created by this Congress, since 1969, that clearly addresses the issues of technical assistance, research and the other things that are necessary to assure that when we do serve the kids, that, in fact, we know what we are doing, both in terms of appropriate designs of programs, and appropriate techniques for serving the children.

We believe that under what we would hope your consideration of EHA next year, that you would take a look carefully at part C, and look at what needs to be done to strengthen the support systems that are going to be necessary to implement it. We believe that the way that the Senate has approached that issue, in S. 2294, is not the best way to go. We believe that it takes changing horses in midstream without knowing what it is doing, and we urge you to re-examine that section very carefully, before you take any action.

I thank you for bearing with us during this statement. We stand ready to work with you, as you progress on this.

[The prepared statement of Frederick J. Weintraub follows:]

STATEMENT OF

THE COUNCIL FOR EXCEPTIONAL CHILDREN

to

THE SUBCOMMITTEE ON SELECT EDUCATION

of

THE U.S. HOUSE OF REPRESENTATIVES

with respect to

S. 2294
THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

July 23, 1986

Submitted by:
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Mr. Chairman and Members of the Subcommittee:

The Council for Exceptional Children is pleased to have the opportunity to convey our views respecting S. 2294, the Education of the Handicapped Amendments of 1986. The Council for Exceptional Children (CEC) is the international association of special education professionals and others concerned about the education of handicapped and gifted and talented children and youth.

The members of The Council for Exceptional Children are well aware of the difficult economic and political times in which we live, because these realities daily affect their ability to deliver quality education to our nation's most vulnerable children. The history of special education is one of being hostage to swings in political sentiment and economic pressures. With the leadership and support of the United States Congress over the past decade, we have been able to significantly improve educational opportunities for many of our nation's exceptional children and youth. But so much more needs to be done if we are to accomplish the mission of developing the potential of these children and youth to the fullest.

There are those who suggest that in this period of economic constraint and political uncertainty we should focus only on defending and maintaining what has already been achieved. The special educators of this nation cannot accept that constraint. The needs of exceptional children are so great and varied, and the children are so vulnerable that we are compelled to seek solutions that address their needs in a fiscal and politically reasonable manner.

In that spirit, Mr. Chairman, we appreciate your action in holding these hearings. We know that your timetable did not call for reauthorization of the Education of the Handicapped Act (EHA) this year. But the Senate has sent the House a reauthorization of EHA, and we are pleased with your response in convening these three days of hearings.

Mr. Chairman, as you are well aware, there still exists a population, namely infant and preschool handicapped children, who critically need special education and other services, for whom federal policy does not assure the provision of such services. The time is long overdue to remedy this omission. In that context, CEC supports the basic objectives and the basic construct of S. 2294 respecting early intervention and preschool education for handicapped children ages birth through five years.

After considerable deliberation with our members in the field, CEC has concluded that S. 2294 inadequately addresses the critical issues in the reauthorization of EHA beyond early childhood issues. In that context, we would observe that your Subcommittee staff and other House staff have been making both an intensive and comprehensive study of the overall EHA in relation to current and future issues and needs. Areas that still require attention and action include, but are not limited to, personnel training, technology, data collection, under-represented populations, recruitment, and transition services.

S. 2294 presents a challenging initiative respecting early intervention and preschool education. But, S. 2294 requires further refinement in that area and we urge you and your colleagues to make it better legislation from the early childhood standpoint. We would further recommend that you restrict your deliberations to the early childhood portions of S. 2294, work for final enactment of these provisions this year, and take up the overall reauthorization of EHA next year. CEC believes that such a legislative schedule will allow a sensible time frame for the preparation of sound legislation in both areas.

EARLY CHILDHOOD

Mr. Chairman, we know of your own continuing advocacy respecting the need for early childhood services for very young handicapped children. CEC is deeply grateful for your continuing pursuit of that mission and we hope to assist you in its achievement.

CEC has come before panels of the Congress to argue the case for early childhood services for at least the last twenty years. In the opinion of the Council, that case is irrefutable. For example, the Department of Education's Seventh Annual Report to Congress on the Implementation of The Education of the Handicapped Act cites numerous studies showing the benefits of early childhood services. That report places special emphasis on the often dramatic savings in potential future costs when early childhood services are provided.

In point of fact, the research indicates that early childhood services for handicapped children and children at risk of being handicapped appears to:

(1) enhance intelligence in some children;

(2) produce substantial gains in motor development, anguage, emotional stability, cognitive abilities and self help skills;

(3) prevent the development of secondary handicapping conditions;

(4) reduce family stress;

(5) increase family income potential;

(6) reduce societal dependency and institutionalizati n;

(7) reduce by up to 50 percent the need for special c ass placement at school age; and

(8) be cost beneficial by as much as 236 percent.

It is clear that early childhood services for handicapped inf nts and young children are essential for the children, their families, our chools, and our society.

Parenthetically, Mr. Chairman, we understand that Dr. Lisbeth Vincent, president of the Division on Early Childhood (DEC) of CEC, wi l be testifying before this Subcommittee. The membership of DEC i composed of individuals with expertise in early childhood education. We ppe that you will give Dr. Vincent's comments your full consideration.

Mr. Chairman, we would like to offer the following major concerns and recommendations toward improvement of S. 2294 in the early childhood area.

CHILDREN AGES THREE THROUGH FIVE YEARS

The objective in the age range of three through five is straightforward: to provide to this age group a free, appropriate, public education as guaranteed to school age children under the basic terms of P.L. 94-142. The Council for Exceptional Children has always sought this goal, and it is perhaps worth remembering that the original versions of what would later be P.L. 94-142 included children three through five. The three through five mandate was removed by amendment in full committee in the U.S. Senate.

Some experts currently estimate, based upon an estimated incidence ranging from 4 to 8 percent, that some 200,000 children would be added to the approximately 266,000 children three through five now receiving special education if the guarantees of P.L. 94-142 were extended to this age group. It is our understanding that, based on data from states currently mandating services, the Department of Education estimates that the unserved population may be as low as 27,000 children. This would suggest a incidence rate of just under 3%. These figures would suggest additional costs to state and local governments as ranging from $185 million to approximately $1 billion. While we realize that these additional costs are significant, The Council for Exceptional Children believes that states, localities, and the profession are ready to meet this important challenge, with federal assistance.

The Children and Their Families

We fundamentally agree with the Senate in their addition of the term "developmentally delayed" to the existing definition for handicapped children in the three through five age category. The Council for Exceptional Children believes this to be an important step in overcoming the problems of labelling children, and, in fact, we believe that the long-standing definition and data reporting requirement for handicapped children in the larger EHA needs to be examined with the same concern in mind.

But, the Senate has not addressed an additional need. We are concerned that for the age range in question parents are a critical part of the instructional process and that services under P.L. 94-142 should include, where appropriate, instruction for parents so that they can be active and knowledgeable members of the instructional team for their child.

Effective Date

The Senate bill designates "three years from enactment" as the final effective date for guaranteeing the provisions of P.L. 94-142 to the three through five age group. We feel that it is important to have a specific date which can be read in the law itself and to have a date which is consistent with the school year. We recommend an effective date of September 1, 1990. Such a date would also be consistent with finalization by the state of their participation in the planning process authorized under

Part C of EHA through P.L. 98-199, the Education of the Handicapped Act Amendments of 1983.

Federal Funding

While we understand that there are efforts in the Senate to achieve a special appropriation of $100 million commencing in fiscal 1987 to assist in serving the three-through five population, S. 2294 simply does not specifically address the question of funding in this area.

Currently, there are two sources for the provision of programmatic funds to serve children three through five years:

- the overall appropriation to the states and localities under P.L. 94-142; and

- the preschool incentive grant program (Sec. 619 of EHA).

We would recommend that in the three-to-four year development phase before the effective date of implementation (September 1, 1990) funding be provided through both of these mechanisms. During that period, the states need maximum flexibility in the use of federal fiscal resources, and the ability to target resources to this population. These combined approaches would provide both flexibility and targeting capacity.

However, we would recommend a new formula for the preschool incentive. The current formula distributes money as a reimbursement, i.e., based upon the number of handicapped children three through five currently being served. Such an approach does not help states not currently serving children in the three through five age range. We would recommend that for the additional dollars appropriated above the current appropriation for the preschool incentive program that a census approach be utilized, i.e., each state's relative population of children ages three through five.

Further, we would recommend that the Congress establish fixed authorization levels. The current formula generates an annual authorization level based upon a count of children served times $300 (for fiscal 1987, 266,000 children generating an authorization level of $79.8 million). We would recommend the inclusion of fixed and progressive authorization levels of $150 million, $200 million, $250 million until the effective date of final implementation. In this fashion, the Congress indicates its own commitment to a fiscal contribution and provides an important incentive through annual increases in that authorization during the development phase.

At the effective date, when handicapped children ages three through five come under the legal umbrella of P.L. 94-142, we recommend that funding for that age group should logically fall within the overall P.L. 94-142 formula and consequent appropriations. But, let us be frank with each other. Current funding for P.L. 94-142, at nine percent instead of the promised 40 percent of the national average per pupil expenditure, is painfully inadequate. When and if the eligible three through five population comes under the same appropriation as the school age population, the lack of dramatically increased appropriations will mean many fewer dollars for all children served whether preschool or school age. The Congress must do its duty and cannot ignore the cost implications of the extension of the service mandate to handicapped children ages three through five.

American Indian Children.

P.L. 94-142 presently authorizes payments to the Secretary of the Interior (according to the need for such assistance) for the education of handicapped children served by Bureau of Indian Affairs (BIA) elementary and secondary schools. While steady progress has been made with respect to special education opportunities for many Indian handicapped children served through federally operated and contracted schools, problems remain with respect to those children requiring services prior to age six.

- The Department of Interior, over the objections of the BIA Advisory Committee for Exceptional Children and The Council for Exceptional Children, amended its FY 1984-86 state plan required under P.L. 94-142 to no longer mandate a free appropriate public education to handicapped children, ages three through four (services to this age range are now permissive).

- Between 1982-83 and 1984-85, the number of handicapped children ages three through five counted as served by BIA has dropped from 323 to 238, a decrease of 26 percent. Although data for comparable years is not available, the number of Indian handicapped children served in Indian Head Start Programs has increased steadily between 1979-80 and 1983-84.

For these reasons, we strongly recommend that the legislation or accompanying report specify that Indian handicapped children ages three through five will be guaranteed appropriate special education and related services through the BIA.

CHILDREN AGES BIRTH THROUGH TWO YEARS

Mr. Chairman, S. 2294 would create a new program for the provision of comprehensive services to handicapped children birth through 2 years of age. CEC supports the objectives and the basic construct of this portion of the legislation, but we believe that further refinement of the legislation must be provided by the House.

Eligible Population

Discussion should continue regarding the definition of "handicapped infants" contained in the Senate bill. From the standpoint of "established" handicapping conditions, we are still uncertain whether this definition is adequate. From the standpoint of children "at risk," the definition is wholly inadequate. CEC has consistently argued that the eligible population should be handicapped infants and infants at risk of being handicapped. The evidence for including "at risk" is abundant, and we would refer you to the continuing study of infants at risk being conducted by the House Select Committee on Children, Youth, and Families. Also, the failure to make provision for "at risk" at the federal level may have a regressive effect in states which are now addressing the needs of this population.

Secondly, the Senate definition includes the term "substantially developmentally delayed." The use of the word "substantially" is inappropriate for this age group, suggesting as it does clinically demonstrable discrepancies, which are simply not functional in the assessment of infants. Curiously, the Senate bill does not include the word "substantially" with the term developmentally delayed in the definition of the population ages three through five.

Scope of Services

In stating what infants and their parents shall be eligible to receive, the Senate bill refers to "necessary services" (Sec. 625(c)(2)). The Senate bill then includes a listing of services, "...which may include but is not limited to ...". We are still uneasy respecting whether this is the best standard in the critical matter of determination of services and we hope to explore this issue further with the House.

Further, the Senate bill defines "early intervention" in the following way: "...means a program of services including special education integrated services as specified in Section 625." This is the second revision of the Senate's original definition of early intervention, and frankly we find it even more confusing than the previous two. This definition is crucial to the successful delivery of services, and must be carefully studied. We have one specific recommendation at this point: the word "integrated" - though the Senate attempted to clarify its meaning in the committee report - is still misleading. We recommend that "integrated" be replaced by "coordinated."

Respecting the individual plan and program for each infant, we observe a notable inconsistency in terminology. This component is variously referred to in the bill as: "written individualized program plan," "early intervention program plan," and "individualized program." We congratulate the Senate for affirming in this legislation the proven value of the individualized approach, but we recommend the term "written individualized service program," and recommend that this term be utilized consistently throughout the final legislation.

Effective Date

We would recommend September 1, 1990, as the "date certain" for final implementation of this early intervention program for all states choosing to participate, for essentially the same reasons cited in our testimony for the effective date for implementation of the mandate for the population ages three through five.

Fiscal Issues

Mr. Chairman, we do not have a reliable estimate of the annual cost of this program once it is fully implemented. Given the vast array of public and private agencies at all levels that would be participating and given the fact that the size of the eligible population is still an open issue in Congressional deliberations, producing a cost estimate remains difficult.

Nonetheless, such a cost estimate should be secured between enactment of this legislation and the point of full provision of services. S. 2294 authorizes an 18 month study by the Comptroller General targeted on the extent and manner in which services are provided by the states. If this study were retained in the final legislation, the study might include an investigation to secure a cost estimate.

S. 2294 contains an authorization for the early intervention program of $100 million for fiscal 1987, 1988, and 1989. Then, at the very point at which the intervention program would be fully implemented by the participating states, the authorization of funds ceases. Such an approach to the federal fiscal commitment is not, to say the least, terribly reassuring to service providers.

In keeping with the underlying psychology of the authorizations now contained in the Part B statutes, namely the permanently authorized formulae for P.L. 94-142 and the preschool incentive grant, CEG recommends a permanent authorization for the new early intervention program. Further, during the development phase, prior to full service implementation, we would recommend the same escalating authorization figures as recommended for the program for children ages three through five, and for the same reasons, i.e., as an expression of federal fiscal commitment and as an important incentive to the states. After the development phase when full service implementation by the states occurs, the Congress might wish to insert an authorization of "such sums."

The Senate Bill includes a census approach in the distribution of funds, but for only the first two years. We support a census approach for the entire development phase for essentially the same reason cited for the three through five program, and are inclined to support a census distribution even beyond full service implementation. But, a final decision respecting the census approach on a permanent basis depends upon final resolution of the definition of the population to be served.

Mr. Chairman, this program will succeed only if it successfully coordinates and utilizes resources at the federal, state, and local level beyond whatever resources are provided for this program itself. The EHA dollars provided for this early intervention program have got to be the "dollars of last resort," as applied, for instance, in the Head Start program. If the availability of this program ends up chasing other resources away when exactly the opposite must occur, then we will have failed in this important mission for handicapped infants and infants at risk. We cannot emphasize this concern too much. There exists a wide array of federal, state, local, and private resources presently available to serve handicapped and at risk infants. This bill presumes the continued availability of those resources. Our experience with P.L. 94-142 has been that non-school based resources that previously served handicapped children were redirected elsewhere when the responsibility for these children's education fell on the schools. If this were to occur for infants the results would be disastrous. Neither states nor the federal government could afford to make up the difference. It is essential that every effort be made in this legislation to prevent this from occurring.

In that context, the Senate bill provides no directives respecting how dollars under this program should be spent. Along with the implication of direct programmatic support for infants and their parents, the structure of S. 2294, however, suggests use of EHA funds for coordination of other public and private resources, for the coordination of comprehensive assessment teams, and for the case management of the written individualized service programs. The Senate has one directive only: a limitation of 10 percent for administrative costs. CEC recommends that the House explore the uses of funds under this program both for the development phase and the post-implementation phase and that the House take a very careful look at what is included in the term "administrative costs."

It is critical that the federal government attend to it own backyard, and it should do so respecting the population birth through two as well as three through five. Various federal programs are now involved in developmental and support programs for handicapped and at risk children ages birth through five, and their families. Examples of these programs include: Medicaid, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Maternal and Child Health Block Grants, Child Welfare Services, Head Start and the Developmental Disabilities program. CEC recommends that the House include in this legislation the authorization of a blue ribbon commission to investigate the participation and potential participation at the state and local level of these and other federal programs in meeting the service delivery missions of this legislation. Based upon the findings of the commission, the Congress and the Executive Branch should then take appropriate action to insure the coordinated participation of these programs in contributing to each state's comprehensive delivery plan. The commission might be required to report its findings and recommendations on a specified date in 1987 or 1988.

Procedural Safeguards

S. 2294 includes a section intended to provide a procedural safeguard system for infants birth through two and their parents. CEC has always been deeply committed to the guarantee of due process procedures for handicapped children of all ages and their parents or guardians, and is committed to such provisions in the early intervention program. Our specific concern is that we design in this legislation a procedural safeguard system which is appropriate and workable. The Senate bill simply grafts onto this legislation the due process section (Section 615) contained in P.L. 94-142, with some adjustments.

We would observe that in the provision of early intervention services a complex of agencies, professions, and legislative authorities are involved. We would further observe that the standard of what services are "necessary" needs continuing exploration. We also think it would be helpful to investigate procedural safeguard systems in the early intervention area already in existence in the states.

American Indian Children

While the Senate bill takes an interagency approach to serving handicapped infants, no mention is made of the role and responsibilities of existing federal agencies providing health, social, and education services to Indian families and children, particularly those residing on reservations. The omission of the Indian Health Service (IHS), BIA Social Services, and BIA Education could very well be interpreted by some as an affirmation of the adequacy of existing delivery systems. Given the long-standing relationship of these service delivery systems to Indian communities, we believe it is essential that IHS, BIA Social Services, and BIA Education be held to a similar standard in terms of interagency cooperation in order to ensure that early intervention programs for Indian handicapped infants are available through these agencies as well.

DEVELOPMENT GRANTS UNDER P.L. 98-199

P.L. 98-199, The Education of the Handicapped Act Amendments of 1983, served as a precursor to the legislation presently before this Committee. Section 623(b) provided for grants to the states for the purposes of planning, developing, and implementing a comprehensive delivery system for the provision of special education and related services to handicapped children from birth through five years of age. All states are presently receiving such grants.

S.2294, with only minor modification maintains these grants incorporating them under Section 628 of the bill. The Council for Exceptional Children proposes that since S.2294 creates specific federal mandates, it would be more appropriate to simplify the language of Subsection 628(a) from three different types of grants to a single grant having the purpose of assisting the state in developing a comprehensive early childhood plan for services to handicapped children from birth through age five as required under Section 623(4) of this Act.

Further, under existing law, ten percent of the funds available for this purpose are directed to training and technical assistance to the states. S.2294 retains this provision, but takes the ten percent from Section 633, The Discretionary Authority for Early Intervention and Preschool Services for Handicapped Children. The Council for Exceptional Children proposes retaining the earmark for training and technical assistance, but the funds should come from appropriations under Section 628.

CONTINUITY OF SUPPORT COMPONENTS

PART C OF EHA, SECTION 623

Mr. Chairman, up till now in our testimony, we have focused on those aspects of S.2294 that relate to developing a system to assure the delivery of services to infant and preschool handicapped children. A second major component of a federal role that is necessary, if the first is to work, relates to being able to develop, demonstrate, and train personnel regarding effective techniques and practices in serving these children. It would be truly meaningless to bring children to services if the service providers do not know how to serve them effectively. Since 1969, the Handicapped Children's Early Education Program (HCEEP) (Section 623 of EHA) has targeted its efforts at improving program capability in early childhood services for handicapped children. This program has had the following major components:

(1) early childhood institutes to conduct sustained research to generate and disseminate new information on early childhood services for handicapped children and their families;

(2) demonstration projects designed to provide locally visible, locally designed quality services through the development of models;

(3) outreach projects to assist others to replicate successfully developed models;

(4) technical assistance to assist projects to meet their objective, use their resources effectively, and share information; and

(5) state planning and technical assistance - This component we previously described.

A study done for the Department of Education by Roy Littlejohn Associates on the impact of the demonstration and outreach program described the accomplishments of these projects as "greater and more varied than for any other documented education program identified." The study found that these projects have contributed significantly to the expansion of services to infant and preschool handicapped children. It is the belief of CEC that the Congress would not be discussing S.2294 today if it had not been for the accomplishments of the HCEEP program.

While we are not here today to defend the status quo, we also do not believe that, given the critical implementation task ahead if S.2294 becomes law, we should "change horses in mid-stream" as the Senate bill proposes, without very careful consideration and input from the field. For that reason, CEC proposes that the House not consider, at this time, amending Section 623 of

EHA and consistent with our previous proposal, take this issue up next year as part of your comprehensive reauthorization of EHA.

Further, we are concerned that the Department, without advice from the field, is significantly altering this program. Recently, the Department announced that it will no longer fund technical assistance to the demonstration projects. It is also our understanding that they plan to discontinue funding of the early childhood institutes. We believe these actions if permitted to occur, could greatly impair the ability of the field to implement this act effectively. We urge this Committee through report language, or other appropriate means, to require the continuity of these programs until the Congress has had the opportunity to consider this matter more fully. We have attached to our testimony a copy of a letter to Assistant Secretary Madeleine Will on the matter of technical assistance and request that it be included in the record.

Before closing, we would briefly like to express our wholehearted support for efforts already underway from members of the Education and Labor Committee to secure for handicapped children birth through five in the Department of Defense schools the same comprehensive early intervention and preschool services under discussion for the nation as a whole.

The Council for Exceptional Children appreciates the opportunity to provide its views to the Subcommittee. We are ready to work with you on these and other matters that will improve the education of exceptional children and youth.

THE COUNCIL FOR EXCEPTIONAL CHILDREN

June 24, 1986

Madeleine C. Will
Assistant Secretary
U.S. Department of Education
Office of Special Education and
  Rehabilitative Services
Mary Switzer Building, Room 3006
Washington, D.C. 20202

Dear Madeleine:

Like many others interested in advancing early childhood special education opportunities, The Council for Exceptional Children (CEC) was astounded to learn that the Office of Special Education Programs (OSEP) does not intend to continue the present contract under which technical assistance is provided to HCEEP (Handicapped Children's Early Education Program) demonstration projects. According to Department officials, this will allow limited technical assistance resources to be targeted at the state level. Even if we might agree that this should be the emphasis in the years ahead, we are deeply concerned about the disruption the decision will have on the program, especially grantees, and would strongly urge you and your staff to carefully reexamine this issue.

Technical Assistance an Integral Part of HCEEP

The decision not to continue the present arrangement for providing technical assistance to HCEEP demonstration projects in the absence of an alternative plan leads one to conclude that the Department no longer views technical assistance as an important ingredient of HCEEP. Moreover, the Department has apparently settled on this course of action without any meaningful consultation with the early childhood special education field or the affected grantees themselves. For the reasons set forth below we believe it is essential that the Department continue its commitment to provide technical assistance to HCEEP demonstration projects:

- Technical assistance has been an integral part of HCEEP since 1971 and in the view of many, it has contributed significantly to the success of the demonstration and outreach projects and is among the principal reasons the demonstration projects have achieved an 85 percent continuation rate once federal funds were no longer available.

- The Department's 1985 RFP, covering a 12 month period for comprehensive technical assistance services, included as a part of the work scope HCEEP first, second, and third year demonstration projects as well as HCEEP outreach projects. For reasons not fully clear, the Department, little more than a year later, apparently has reversed itself and would now end technical assistance altogether to these projects.

1920 ASSOCIATION DRIVE
RESTON, VIRGINIA 22091 (703) 620-3660

Madeleine C. Will
June 24, 1986
Page two

- In authorizing the state early childhood planning, development, and implementation grants in the 1983 amendments to the Education of the Handicapped Act (EHA), Congress recognised the importance of technical assistance to the long term success of this new program and specified that a portion of the funds be used for technical assistance. This action was based, in part, on an acknowledgment of the effectiveness of the technical assistance provided by the Technical Assistance Development System (TADS) to HCEEP.

- The Senate bill (S. 2294) to reauthorise and amend EHA would place in statute for the years ahead an authority for technical assistance to programs of experimental early intervention for both handicapped infants and young children. This is but another reaffirmation of the importance of technical assistance to programs designed to address areas of emerging or unmet needs.

Alternative Plan Needed

We would not want you or your staff to interpret our comments as an affirmation of the status quo; we have always felt it was the responsibility of the Administration to continually strive to improve the programs which it administers. In this particular instance, however, the timing of the decision and the lack of an alternative approach to providing technical assistance to approximately 70 HCEEP demonstration projects would not appear to be in the best interests of HCEEP or individual grantees and is unduly unfair to TADS who, from almost all accounts, has an exemplary record during the time it has provided technical assistance to HCEEP.

In addition, the absence of another means of providing technical assistance to the HCEEP demonstration projects raises questions about the apparent redirection of an estimated $500,000 available for this activity this year. Even with the 4.3 percent reduction under the terms of Gramm-Rudman-Hollings, HCEEP is some $470,000 above last years funding level. It would, thus, appear that sufficient funding is available to continue some form of technical assistance to these projects.

We realise the Department has devoted substantial attention to the area of early childhood education and has most recently been studying how best to fashion and organise future programs and services to handicapped infants and young children. With respect to enhancing technical assistance, the Department's National Task Force of the Future of Early Childhood Education recommended the following:

> Technical Assistance. Although some of the technical assistance in the future would be handled through the coordination and brokering which results from the federal monitoring effort, there

is an ongoing need for a national technical assistance effort such as that now provided by TADS and WESTAR.

In closing, we believe there is substantial evidence supporting the need to continue to make technical assistance available to those conducting three-year HCEEP model demonstration projects to enhance the effectiveness of these projects. In view of this as well as the need to avoid any further disruptions among grantees and at TADS, we urge that this issue be reconsidered.

If we can be of further assistance in providing additional information to you or if we can answer any questions that you or your staff members may have, please do not hesitate to contact us.

Sincerely,

Fred Weintraub
Frederick J. Weintraub
Assistant Executive Director
Department of Governmental Relations

Joe Ballard
B. Joseph Ballard
Associate Director
Department of Governmental Relations

FJW/BJB/ymb

cc: Patricia Guard
Tom Behrens
Tom Finch

Mr. **Williams**. Thank you, Mr. Weintraub.

Frank New is the Ohio State Director of Special Education, and he is here representing the National Association of Special Education Directors.

Mr. New, it is nice to have you with us, and please, proceed.

STATEMENT OF FRANK NEW, OHIO STATE DIRECTOR OF SPECIAL EDUCATION, REPRESENTING THE NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION

Mr. **New**. Mr. Chairman, and members of the subcommittee, my name is Frank New. I am Director of Special Education for the State of Ohio. I also serve as a member of the Board of Directors for the National Association of State Directors of Special Education, and I serve as Chair of our Legislative Committee.

Thank you for giving us this opportunity to present the views of State Directors of Special Education on the topic of the reauthorization of the Education of the Handicapped Act.

We started a process in November, trying to identify the areas that would improve the administration of 94-142 and the Education of the Handicapped discretionary program. We have identified those areas for which we have arrived at a consensus of all State directors in a document in attachment 2, which I would share with you.

We are currently—since January we have had staff working with the Senate Subcommittee on the Handicapped, to develop the design of S. 2294. The points that I would like to share with you today reflect only those areas that we have, as a legislative committee in this organization, arrived at a consensus. We will continue to study the bill, and I am certain that we will continue to have input that we feel would be improvements, and we will be happy to offer that.

To set the stage for a few specific comments, or recommendations that I would like to make about S. 2294, I would like to state, first of all, that NASDSE acknowledges that there ought to be a Federal and a State policy on services for all children, all young children, especially young handicapped children.

Second, we believe that in order for a successful implementation, we have to see the partnership between the Federal and State, particularly, the funding partnership that was envisioned in the original Education of the Handicapped Act.

Third, we believe that we should reauthorize this year, and finally, we believe that, for the most part, S. 2294, in principle and intent accomplishes those activities that we feel are important.

Some specific comments or recommendations regarding S. 2294, there are 10 of them listed. The first one is that we believe that the 3 through 5 program, when the mandate is arrived at, should be funded as part of the core 94-142 program.

Item two, for the birth through 2, we believe that the funding should always be on a census basis, rather than a head count. Given a census funding formula, States should be given the responsibility, the opportunity, the flexibility to determine the eligibility criteria for the population.

States should be allowed to operationally define the term "developmentally delayed" for the 3 through 5 program.

Whether there should be any revisions to the existing mandates contained for 5 through 17, as it would apply to 3 to 5, we believe should be identified through the study, the General Accounting Office study that is indicated in S. 2294.

We believe that the qualifications of service providers is a topic that should be defined and determined by the States and that a timeline be established of September 1, 1990, as the implementation date for the mandate.

The State education agency should be designated as the administering agency for the program birth through 2. That the technical amendment concerning the monitoring and complaint management activities is of benefit—will be of great benefit to the SEA's in carrying out their responsibilities.

We believe that the discretionary programs, as covered by S. 2294, do, in fact, meet the objectives that our organization has set out. S. 2294 recognizes the continuation of the Regional Resource Center as a mechanism for a State grant, to each State Education Agency for personnel preparation and it continues the program development and implementation grants for early childhood, while recognizing the continued emphasis on looking at transition issues. It could be improved, if we could identify how the State Education Agency could be more directly involved through a grant mechanism.

Mr. Chairman, the foregoing statements represent our position at this time. Please be assured that our national office staff and our membership stand ready to work with you in providing any further justification for these recommendations, and to assist you in anyway that we can, as you deliberate on the reauthorization legislation.

Thank you.

[The prepared statement of Frank New follows:]

STATEMENT OF

THE NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION, INC.

TO

THE SUBCOMMITTEE ON SELECT EDUCATION

OF

THE HOUSE OF REPRESENTATIVES

WITH RESPECT TO

REAUTHORIZATION OF THE EDUCATION OF THE HANDICAPPED ACT

July 23, 1986

SUBMITTED BY:

Frank New, Member of NASDSE
Board of Directors, Chair of the
NASDSE Legislative Committee,
and Director of Special Education,
Ohio Department of Education

Mr. Chairman and Members of the Subcommittee:

My name is Frank New. I am Director of Special Education for the State of Ohio, a member of the Board of Directors of the National Association of State Directors of Special Education, and Chairman of NASDSE's Legislative Committee.

Thank you for allowing us this opportunity to present the views of state directors of special education regarding reauthorization of the Education of the Handicapped Act.

By way of background, the views I put forth today represent consensus views of all state directors. We have been working since last November to identify improvements in both P.L. 94-142 and in the EHA discretionary programs which we believe will both strengthen our ability to administer those programs and improve services to handicapped children. Since January we have also worked closely with and provided extensive input to staff of the Senate Subcommittee on the Handicapped as it first conceived and then developed S.2294. We are continuing to study the bill. The comments I will make today reflect our views on only some aspects of S.2294.

First, I need to preface those comments and recommendations with a few remarks:

- The decade of the 90's will see a tremendous population boom in the number of children birth-5, correlated with continuing increases in the number of single-parent families, children born to teenage mothers, children born in conditions of low income, poor prenatal care, and poor nourishment. In fact 40 teenagers give birth to their third child, every day. As the "baby boom" occurs, the numbers of handicapped infants will increase with it. (See attachment #1)

- NASDSE acknowledges the need for federal and state policy regarding services to all young children, especially young handicapped children. We believe it is clear that services for handicapped infants and young children are essential and efficacious not only for the children, but for their families and for society.

- NASDSE endorses, in general, the direction, and intent of S.2294. We believe, for the the most part, it enhances our ability to administer special education programs and improves services for handicapped children.

- To be successful, the birth-2 and 3-5 initiatives of S.2294 will require a full partnership between the federal government and states. The funding partnership promised by Congress in P.L. 94-142 has never been fulfilled. The birth-2 and 3-5 programs will require new and extensive expenditures by almost all states. Congress needs to be reminded that adequate funding of P.L. 94-142 and the birth-2 program will fulfill the partnership promise, insure the full success of P.L. 94-142, and ensure the success of the proposed birth-2 and 3-5 programs. Without adequate funding, Congress runs the risk of a "backlash" of attitudes for programs for the handicapped and risks only partial achievement of programs which we believe to be essential.

- NASDSE endorses reauthorization this year.

S.2294: Recommendations and Comments

This section will provide a profile of comments of the NASDSE membership concerning S.2294. We will be happy to provide full explanations or rationale to you upon request and we will be happy to work with you on these or any other improvements as you develop your legislation to reauthorize the EHA.

1. When the 3-5 mandate begins it should be funded through the core P.L. 94-142 program, which should be increased substantially to reflect the full partnership promised in 1975.
2. States should always receive funds for the birth-2 program on a census basis rather than on a "head count" basis.
3. Given a census funding formula, states should be given the responsibility and the flexibility to define eligibility criteria for the birth-2 program.
4. States should be allowed to operationally define the term "developmentally delayed" for the 3-5 program.
5. Whether any variations from the 5-17 mandate are necessary or proper for the proposed 3-5 mandate should be determined by the GAO Study included in S.2294.
6. Qualifications of service providers should be determined by the states.
7. The timeline for states to lower the P.L. 94-142 mandate should be September 1, 1990.
8. The State Education Agency should be designated as the administering agency for the birth-2 program unless that agency agrees that another agency be so designated.
9. The "technical" amendment to P.L. 94-142, (Sec. 1411) will assist SEAs in carrying out expanding monitoring and complaint management activities.
10. S.2294 incorporates many of NASDSE's recommendations to improve the discretionary programs. It continues to authorize the Regional Resource Center program; it authorizes (Part D) personnel training grants to each State Education Agency; and it continues the early childhood planning, development and implementation grants although it does not authorize the grant through the State Education Agency as is currently authorized. S.2294 does not incorporate our suggestion that the transition initiative would be improved substantially if SEAs were identified in legislation as prime recipients of grants under Section 1425(a) of P.L. 98-199, (see Appendix II).

Mr. Chairman, the foregoing statements represent our position at this time. Please be assured that our national office staff and our membership stand ready to work with you in providing any further justification for these recommendations and to assist you in any way as you deliberate on reauthorization legislation.

Thank you for the opportunity to testify.

APPENDIX I

Demographic Trends in the U.S.

1.

POPULATION TRENDS - GROWTH OF THE POPULATION

As the population increases, the demand for services increases. The Population of the United States increases by 10% every decade.

POPULATION INCREASE FOR THE UNITED STATES

Year	Population	%
1970	203,212,000	
1980	226,546,000	+10
1990	249,204,000	+11

Source: U.S. Bureau of the Census, "1980 Census of Population" Washington, DC, 1980

POPULATION TRENDS: GROWTH OF THE 0 - 4 AGE GROUP

The growth of the 0 - 4 population in the United States in 1980 fell below that in 1970. It is expected to increase again in 1990.

POPULATION UNDER 5
IN THE UNITED STATES

Year	Population	%
1970	17,154,000	
1980	16,348,254	-4.7
1990	19,199,700	17.5

Source: "State Demographics: Population Profiles of the 50 States" (Prepared by the American Demographics Magazine Editors) Homewood, Illinois: Dow Jones-Irqin, 1984.

3.

POPULATION TRENDS - PUBLIC SCHOOL ENROLLMENT

States across the nation have experienced a considerable drop in the need for services at the high school level as a result of the declining birth rate in the 1970s.

School enrollments across the country have declined dramatically in elementary grade levels. These smaller cohorts of children are now arriving at the junior and senior high school levels.

PUBLIC SCHOOL ENROLLMENT
IN THE UNITED STATES
K THRU GRADE 8

Year	Population
1975	30,545,000
1982	27,143,000

a drop of 11%

Source: U.S. Bureau of the Census, "Statistical Abstract of the United States: 1985" (105th edition.) Washington DC, 1984 [illegible].

CONDITIONS FOR CHILDREN - TEENAGE PARENTS IN THE U. S.

> Teenagers are the parents of 25% of all the children born in the United States.

To the extent to which risk is associated with birth with teenage mothers, the number of children at risk in the United States is increasing.

The job of providing services to young children is intensified when children are born in conditions of poverty.

Children are not just being born to very young women, they are also being born in conditions of low income, poor prenatal care, and poor nourishment.

One out of four adolescent girls becomes pregnant. In fact, 40 teenagers give birth to their third child, every day.

Seven hundred thousand children are illegitimate in the current birth cohort of 3,700,000

APPROXIMATE BIRTH RATES BY AGE OF MOTHER (x1000)

Age	1945	1950	1955	1960	1965	1970	1975
15-19	130	160	170	160	150	150	120
20-24	175	250	275	290	250	200	150
25-29	140	170	230	225	180	150	125
30-34	97	110	150	140	130	80	61
35-39	51	62	70	70	66	42	20
40-44	23	22	73	22	18	13	8

Source: U. S. National Center for Health Statistics, "Vital Statistics of the United States" Washington, DC published monthly.

5.

CONDITIONS FOR CHILDREN - DIVORCE RATES

Nearly half of all the marriages in the United States ended in divorce in the 1980s.

The frequency of divorce in the United States is described in terms of rates per thousand married women and in terms of divorce rate per 1000 marriages. The latter statistic shows that divorces for every thousand marriages. In 1970 the number had increased to 328 divorces. By 1980, the number of divorces per thousand marriages had increased to 490.

NUMBER AND RATE OF DIVORCE IN U.S.

Year	Number in U.S.	Rate Per 1,000 Married Women
1960	393,000	9.2
1965	479,000	10.6
1970	708,000	14.9
1975	1,036,000	20.3
1980	1,189,000	27.6

Source: U.S. National Center for Health Statistics, "Vital Statistics of the United States" Washington, DC published monthly.

*Andrew Hecker, "A Statistical Portrait of the American People." New York: The Viking Press, 1983.

6.

CONDITIONS FOR CHILDREN - NUMBER OF CHILDREN OF DIVORCES NATIONALLY

More than 1,000,000 children are involved in divorces each year.

Divorces do not always involve children, but families with children are a significant number of the divorced couples. In 1980, for example 536,644 divorces in the United States involved children.

CHILDREN INVOLVED IN DIVORCE
IN THE UNITED STATES SINCE 1960

1960	475,000
1965	650,000
1970	850,000
1975	1,130,000
1980	1,175,000
1982	1,100,000

Source: U. S. National Center for Health Statistics, "Vital Statistics of the United States" Washington, DC published monthly.

7.

CONDITIONS FOR CHILDREN - PROFILE OF CHANGING AMERICAN FAMILY

More than 80% of American families do not have a parent available in the home during the work day.

Service programs that are based on the assumption that an adult is available at home, has time for meeting attendance, has time for volunteer work, has time for training, etc., may find it difficult to operate. The "free time" parent is vanishing from the American scene.

MODELS FOR THE AVERAGE AMERICAN FAMILY

Model #1	Housewife, working father, 2 kids in school	11%
Model #2	Single parent, 1 or more kids in school	59%
Model #3	Both parents working, 1 or more kids in school	25%

Source: "State Demographics: Population Profiles of the 50 States" (Prepared by the American Demographics Magazine Editors) Homewood, Illinois: Dow Jones-Irwin, 1984.

8.

CONDITIONS FOR CHILDREN - COMPOSITION OF HOUSEHOLDS IN THE UNITED STATES

Households headed by either a single woman or a single man has increased by almost 50% in the past 10 years.

The demographic statistics show a dramatic increase in households headed by a single individual. Of the nearly 8.5 million homes headed by a woman, 62.5% have at least one child under the age of eighteen. Of the nearly 2 million homes headed by single men, 35.7% have at least one child under the age of eighteen.

TOTAL NUMBER AND COMPOSITION OF FAMILY HOUSEHOLDS IN UNITED STATES

	1970	1980	% Change
Number of Family Households	50,968,027	58,882,153	+ 15.5
Non-Family Households	12,480,920	21,507,520	+ 72.3
Households Headed by Single Women	5,504,100	8,409,168	+ 52.8
Households Headed by Single Men	1,402,347	2,101,979	+ 49.9

Source: "State Demographics: Population Profiles of the 50 States" (Prepared by the American Demographics Magazine Editors) Homewood, Illinois: Dow Jones-Irwin, 1984.

APPENDIX II

Legislative and Action Initiatives

National Association of State Directors of Special Education, Inc.
2021 K St., N.W., Suite 315, Washington, D.C. 20006 202/296-1800

ACTION
AGENDA

REPORT March 26, 1986

RE : Legislative and Action Initiatives, 1986

FROM: Frank New (OH) and Bill Schipper (NASDSE)

This report represents a consensus position of state directors of special education (NASDSE) on 13 "action initiatives" for 1986-87. Those initiatives cluster into five categories, representing five types of actions. They are:

- o Seek Appropriate Achievement of the Federal/State Funding Partnership for P.L. 94-142
- o Seek Technical Amendments to P.L. 94-142
- o Seek Technical Amendments to P.L. 98-199
- o Provide Recommendations to Congress on Attending to Emerging Issues
- o Seek Cooperation/Joint Initiatives with OSERS/OSEP

Background

1. At the conclusion of the 1985 Annual Meeting in Sacramento, NASDSE President Gary Makuch (PA)initiated a legislative committee, to develop recommendations for legislative and other action initiatives during 1986.

2. Eighteen state directors then provided input to a preliminary "action agenda". That agenda (attached) subsequently was reviewed, amended and approved by the Executive Board at its January meeting in Albuquerque, New Mexico.

3. The National Office then surveyed all State Directors seeking responses as to agreement on the priority of issues, and appropriateness of proposed recommendations.

4. This report was then presented to the Legislative Committee of the Council of Chief State School Officers and to the Executive Board of NASDSE. The NASDSE Board formally adopted the report on March 19, 1986.

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NASDSE Legislative Committee, 1985-86

Frank New, Chairperson
Ohio

Tom Gillung
Connecticut

Wendy Cullar
Florida

Joe Fisher
Illinois

James Marshall
Kansas

Vivian Link
Kentucky

Irene Newby
Louisiana

David Stockford
Maine

Roger Brown
Massachusetts

Norena Hale
Minnesota

John Allan
Missouri

Elie Gutierrez
New Mexico

Larry Gloeckler
New York

Gary Gronberg
North Dakota

Robert Black
South Carolina

George Levin
South Dakota

JoLeta Reynolds
Tennessee

Judy Schrag
Washington

Miles Kawatachi
Hawaii

ACTION
AGENDA

A. *FULL FUNDING;* P.L. 94-142

1. FEDERAL/STATE FUNDING PARTNERSHIP

ISSUE STATEMENT

While the implementation of P.L. 94-142 is characterized as a local, state and Federal partnership, the data reflects that states and local school districts continue to provide at least 90% of the cost of educating handicapped children. The Federal partner not only must continue to share in the cost but should move toward the 40 percentum average per pupil expenditure in the public elementary and secondary schools in the United States as called for in the Act. Even if funded at only 12% of MAPPE, the appropriation figure would be $1,435,000,000 which is $220 million more than was appropriated in FY '86 before Gramm-Rudman cuts.

CONGRESSIONAL RESPONSIBILITY FOR PROVIDING FEDERAL FINANCIAL SUPPORT FOR STATE SPECIAL EDUCATION PROGRAMS

Summary

As a result of the enactment of P.L. 94-142 and the subsequent submission and acceptance of State Plans submitted under Part B of the Education of the Handicapped Act (EHA-B), Congress has become legally responsible for "fully funding" for State special education programs receiving support under Part B or, at a minimum, continuing at least the current level of financial support.

Background

In 1975 Congress created through the Education for All Handicapped Children Act ("P.L. 94-142") a comprehensive Federal education grant and civil rights program to ensure that all school aged handicapped children in the United States were provided an opportunity for a free appropriate public education.

In Section 3 of that statute (20 U.S.C. 1401) Congress specifically found that "State and local education agencies have responsibility to provide education for all handicapped children, but present financial resources are inadequate to meet the special education needs of handicapped children...." (EHA-B, Section 601(b)(8)).

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In light of Congress' general assessment of the availability in States of financial resources sufficient to support and insure the full and swift implementation of the Act, Congress concluded that "it is in the national interest that the Federal Government assist State and local efforts to provide programs to meet the educational needs of handicapped children in order to assure equal protection of the law." (EHA-B, Section 601(b)(9)). The reference to "equal protection of the law" clearly links this statute with the equal protection guarantees of the Fourteenth Amendment which, in fact, had been the legal basis for the series of "right-to-education" cases from which much of the procedural framework for P.L. 94-142 was derived.

Rationale for On-Going Congressional Financial Responsibility

In order to establish a sound financial base for the full implementation of the Act, Congress established a schedule for Federal financial participation which called for the Federal contribution for special education and related services to increase at the following pace:

FY 78	5% of National Average per pupil expenditure
FY 79	10% of National Average per pupil expenditure
FY 80	20% of National Average per pupil expenditure
FY 81	30% of National Average per pupil expenditure
FY 82	40% and thereafter of National Average per pupil expenditure

P.L. 94-142 provides that States which wish "to qualify for assistance under this part" and States "meeting the eligibility requirements" set forth in the statute and "desiring to participate in the program under this part" shall periodically submit State Plans to the Secretary of Education which contain a series of assurances, policies and procedures mandated by P.L. 94-142 (EHA-B, Sections 612(a), 613(a)).

During the initial years of implementation of the requirements of P.L. 94-142 a majority of States enacted new State special education laws and established related special education financing systems to carry out the State legal and financial responsibilities mandated by the new statute. Because of the gradually increasing Federal contribution called for by the statute, State and local educational agencies were responsible for 95% and 90%, respectively, of the average per pupil expenditure during each of the first two years of implementation. Accordingly, State legislatures, assured by the statute that the State financial share would be dramatically reduced during the subsequent three years (to 60% in FY '82 and thereafter), appropriated substantial funds for this short-term implementation period. Accordingly, virtually every State submitted in 1977 or 1978 an acceptable EHA-B State Plan. These State Plans and their successors have been held by the Federal courts to be a binding legal commitment by a State to carry out its legal, financial and programmatic responsibilities under the statute. In fact, all States have submitted and currently have State Plans approved by the Secretary of Education. Federal support for the state special education program mandated by P.L. 94-142, falls short of even the 10% standard established for FY 79. In this context, the "binding contract" between the States and the Federal Government has been repeatedly breached by the Congress since 1979. If, in fact, a binding contract exists between the States and the Federal government (the beneficiaries of which are the handicapped children of this nation) then either the States or the legal representatives of such handicapped children should be entitled to enforce the financial obligation of the contract currently by the Congress. Indeed, States have relied to their detriment on the statutory promise of Federal financial support and, therefore, should have a right to enforce the original statutory contractual terms.

SPECIFIC RECOMMENDATIONS FOR ACTION

1. Advocate aggressively with Congress and the White House on the importance of progressing towards the 40% of the national average per pupil expenditure funding level promised by 1982 in Section 1411(a)(1)(B)(v) of P.L. 94-142.

ACTION
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B. TECHNICAL AMENDMENT: P.L. 94-142

1. ADMINISTRATIVE BURDEN vs. ADMINISTRATIVE FUNDS: THE "5% OR $350,000 FORMULA". (Section 1411)

ISSUE STATEMENT

Many states currently and all states in the future will have difficulties fulfilling all of the administrative responsibilities as called for in current Federal legislation and Federal regulations (such as monitoring, data collecting and reporting, etc.). While full funding of the Act would eliminate this crisis, some immediate legislative change to allow greater access to administrative funds is needed.

SPECIFIC RECOMMENDATIONS

The following technical amendment to PL 94-142 would provide SEAs authority to use a portion of 25% set aside funds for certain administrative purposes. The Amendment would not require additional allocations, or reduce funds to LEAs, and is supported by NASDSE and CCSSO. Sec. 1411(b)(2)(B) would be amended to read:

Current Language	Amended Language
(B) the remainder shall be used by such State to provide support services and direct services, in accordance with the priorities established under section 1412(3).	"(B) the remainder shall be used by such State to provide support services and direct services, in accordance with the priorities established under Section 1412(3), and for the administrative costs of monitoring and complaint investigation, but only to the extent that such costs exceed the costs for these activities incurred during fiscal year 1985."

B. TECHNICAL AMENDMENT: P.L. 94-142

2. FORMULA FOR COMPUTING "12% CAP" ON CHILD COUNT. (Section 1411)

ISSUE STATEMENT

A change in the provision of the law related to the "12% cap" on the number of students a state may count for purposes of receiving PL 94-142 funds (SEC. 1411.(a)(5)(A)(i)) is needed.

The present formula has the effect of discriminating against states, or providing a disincentive to states, which serve handicapped children in the 3-5 and 18-21 age ranges.

While the 12% cap should be retained, the ages of the total population and the ages of the handicapped children served used in the formula to compute the percent served should be comparable.

SPECIFIC RECOMMENDATIONS

NASDSE will support a technical amendment to Sec. 1411(a)(5)(A) to read:

Current Language	Amended Language
"(5) (A) In determining the allotment of each State under paragraph (1), the Commissioner may not count- "(i) handicapped children in such state under paragraph (1)(A) to the extent the number of such children is greater than 12 percentum of the number of of all children aged five to seventeen, inclusive in such state."	"(5)(a) In determining the allotment of each state under paragraph (1), the Commissioner may not count -- (i) handicapped children in such state under paragraph (i)(A) to the extent the number of children aged 5-17, inclusive receiving a free appropriate public education, in such state is greater than 12% of the number of all children aged 5-17, inclusive, in such state."

ACTION
AGENDA

B. TECHNICAL AMENDMENT: P.L. 94-142

3. PRESCHOOL INCENTIVE GRANTS: "COUNTING" OF CHILDREN BIRTH - THREE. (Section 1419)

ISSUE STATEMENT

The preschool incentive grants (PIG) program has been very effective in assisting states [in providing services and developing policy to serve young handicapped children.] The state planning grants have increased communication and awareness of the needs of the birth to age 5 population. The research, demonstration and outreach projects have shown the positive results of these programs; access to early education programs must become a reality for every handicapped child. The preschool incentive grant program should be extended to the entire age group birth to 5 and additional appropriations made available by Congress to support this change.

SPECIFIC RECOMMENDATIONS FOR ACTION

1. NASDSE will compile a report of states which serve 0-3 handicapped children and the number of children served in each state during 1985-86 (attached).

2. NASDSE will advocate a legislative change which allows SEAs to "count" children served (0-3) under the PIG program (Section 1419(a)(3)).

Current Language	New Language
"Sec. 1414(a) The Commissioner shall make a grant to any State which - "(1) has met the eligibility requirements of sec. 612; (2) has a State plan approved under sec. 613; and (3) provides special education and related services to handicapped children aged three to five, inclusive, who are counted for the purposes of sec. 611(a)(1)(A).	(3)..Birth to five...

TABLE 1. Minimum Ages Mandated by States and Territories for Providing Special Education to Handicapped Children: July 1985

Birth	Age 2	Age 3	Age 4	Age 5	Age 6 or "School-age"
Iowa	Virginia	Alaska	Delaware a/	Arizona	Alabama
Maryland		California	Minnesota	Arkansas	Florida
Michigan		Connecticut	Oklahoma b/	Colorado	Georgia
Nebraska		District of Columbia	Tennessee	Kansas	Idaho
New Jersey		Hawaii		Maine	Indiana
Oregon		Illinois		Missouri	Kentucky
South Dakota		Louisiana		Nevada	Mississippi
American Samoa		Massachusett		New Mexico c/	Montana
Trust Territory		New Hampshire		New York	Vermont
Guam		North Dakota		N. Carolina	Wyoming d/
		Rhode Island		Ohio	
		Texas f/		Pennsylvania e/	
		Washington		S. Carolina	
		Wisconsin		Utah	
		Northern Marianas		W. Virginia g/	
				Puerto Rico	
				Virgin Islands	

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a/ Mandates services for deaf, blind, deaf-blind, and autistic children from birth; mandates services for orthopedically impaired, severely mentally handicapped, and trainable mentally handicapped from age 3.

b/ Mandates services for deaf-blind and "failure to thrive" from birth.

c/ Will phase-in mandated services for 3 year old developmentally disabled children by 1988.

d/ Health and social services are mandated for children from birth.

e/ Services mandated from 4 years 7 months.

f/ Mandates services for visually impaired, hearing impaired and deaf-blind from birth.

g/ Will phase-in mandated services for severely handicapped by 1987.

The following table indicates children receiving special education and related services under the P.L. 94-142 and the preschool incentive grant program in school year 1984-1985 as reported by States to SEP. Total children served that year from birth through age 5 were about 295,000, about 88 percent of whom were between the ages of 3 and 5.

TABLE C. Handicapped Children Birth Through Age 5
Receiving Special Education Services During the School Year 1984-1985,
As Reported By States to the U.S. Department of Education

State	Numbers of Children 0-2 Years Old	Numbers of Children 3-5 Years Old
Alabama	2,004	3,047
Alaska a/	957	633
Arizona	192	2,086
Arkansas	379	2,473
California a/	1,898	21,476
Colorado	689	1,899
Connecticut a/	*	3,503
Delaware	45	805
District of Columbia a/	*	515
Florida	859	7,308
Georgia	167 est.	4,710
Hawaii a/	*	512
Idaho	845	1,253
Illinois a/	202	20,287
Indiana	1,156	4,865
Iowa b/	802	5,497
Kansas	246	2,488
Kentucky	821	4,005
Louisiana a/	966	6,072
Maine	282	2,465
Maryland b/	911	5,930
Massachusetts a/	2,479	6,534
Michigan b/	1,833	12,807
Minnesota	520	8,323
Mississippi	36	1,492
Missouri	88 est.	6,449
Montana	74	1,565
Nebraska b/	981	2,761
Nevada	296	799
New Hampshire a/	0	1,011
New Jersey b/	2,866 est.	12,180
New Mexico	250	1,210

TABLE 2. Handicapped Children Birth Through Age 5 Receiving Special Education Services During the School Year 1984-1985, As Reported By States to the U.S. Department of Education--Continued

State	Numbers of Children 0-2 Years Old	Numbers of Children 3-5 Years Old
New York	3,133	7,243
North Carolina	246	6,1[illegible]
North Dakota a/	205	948
Ohio	115 est.	7,699
Oklahoma	481	5,703
Oregon b/	47 est.	1,393
Pennsylvania	3,428 est.	8,520
Rhode Island a/	222	1,130
South Carolina	258	5,001
South Dakota b/	208	895
Tennessee	215	7,570
Texas a/	1,872	19,570
Utah	116	2,364
Vermont	88	524
Virginia c/	*	9,798
Washington a/	388	4,990
West Virginia	427	2,293
Wisconsin a/	1,395	8,337
Wyoming	48	392
American Samoa b/	*	14
Guam b/	27	113
Puerto Rico	*	1,741
Trust Territory b/	*	+
Virgin Islands	*	13
Northern Marianas a/	*	+
Bureau of Indian Affairs	32	+
TOTAL	35,795	259,418

a/ State has mandate to serve all handicapped children from age 3.

b/ State has mandate to serve all handicapped children from birth.

c/ State has mandate to serve all handicapped children from age 2.

* Not reported.

+ Non-participant in preschool incentive grant program.

Source: U.S. Department of Education, Office of Special Education Programs. Unpublished data.

ACTION AGENDA

C. REAUTHORIZATION: P.L. 98-199

1. THE FEDERAL/STATE PARTNERSHIP ROLE IN PRESERVICE/INSERVICE TRAINING. (Section 1432)

ISSUE STATEMENT

Much has been accomplished in the preparation of qualified special educators and administrators to serve handicapped children. Shortages now exist or are projected in the next five years, though specific shortages vary across the states. The current Federal personnel development effort must be continued but a closer link must be established between the allocation of funds by OSEP within a state to each state's Comprehensive System of Personnel Development program based on the data on teacher supply and demand.

SPECIFIC RECOMMENDATIONS

Section 1432 of P.L. 98-199 should be amended to allow a Part D Grant to be awarded to each state which meets application requirements. The amendment would read (Sec. 1432):

Current Language	New Language
"Sec. 632. The Secretary shall make grants to State educational agencies to assist them in establishing and maintaining, directly or through grants to institutions of higher education, programs for the preservice and inservice training of teachers of handicapped children, or supervisors of such teachers. "Grants to improve recruitment of educational personnel and dissemination of information concerning educational opportunities for the handicapped."	The Secretary shall make grants to each State Educational Agency to assist in establishing and maintaining, directly or through grants to institutions of higher education, local education agencies, or other appropriate public and private nonprofit institutions or agencies, programs for the preservice and inservice training of teachers of handicapped children, or supervisors of such teachers.

ACTION
AGENDA

C. REAUTHORIZATION: P.L. 98-199

2. TRANSITION PROGRAMS: GRANTS TO STATES. (Section 1425)

ISSUE STATEMENT

The momentum must be continued for the improvement of secondary programs and transitional services for all handicapped youth. A new program of Discretionary grants to SEAs or states to coordinate with all appropriate agencies to plan, develop and implement transition programs and projects (similar to early childhood programs) should be created through legislation.

SPECIFIC RECOMMENDATIONS

NASDSE will advocate for new legislation or regulation to establish a grants program to SEAs or states to assist them in planning, establishing or maintaining coordinated transition services to secondary aged handicapped students and for the inservice training of teachers and administrators of special education programs.

Sec. 1425 of P.L. 98-199 should be amended to create a separate authority for the Secretary to make grants with SEAs.

Current and Amended Language	New Language
"Sec. 1425(a) (a) The Secretary is authorized to make grants to, or enter into contracts with, institutions of higher education, ~~State educational agencies~~, local educational agencies, or other appropriate public and private nonprofit institutions or agencies (including the State job training coordinating councils and service delivery area administrative entities established under the Job Training Partnership Act (Public Law 97-300) to-	(b)(1) The Secretary is authorised to make grants to, or enter into contracts with, each State Educational Agency to assist in establishing or maintaining, directly or through grants to institutions of higher education, local education agencies, other appropriate public and private nonprofit institutions or agencies including the State job training coordinating councils and service delivery area administrative entities established under the Job Training Partnership Act (Public Law 97-300) to --

C. REAUTHORIZATION: P.L. 94-199

3. REGIONAL RESOURCE CENTERS. (Section 1421)

SUPPORT STATEMENT

The regional resource centers continue to provide valuable assistance to state education agencies and assist in equalizing the professional and technical resources among large and small, rural and urban states. They provide an effective vehicle for the exchange of information on both effective and ineffective policies and practices. These services should be continued.

ACTION
AGENDA

D. EMERGING ISSUES

1. POSTSECONDARY PROGRAMS FOR HANDICAPPED YOUNG ADULTS.

ISSUE STATEMENT

As our society and our workforce go through dramatic changes we must expand and create opportunities for adult handicapped individuals to participate in needed retraining. Federal programs for adult, continuing education and postsecondary need to make provisions for more participation of handicapped students.

SPECIFIC RECOMMENDATION

Congress should target all adult, continuing education or postsecondary education grants programs administered by the U.S. Department of Education should be amended to require at least a 10% grants "set aside" for handicapped young adults.

D. EMERGING ISSUES

2. CHILDREN WHO ARE MEDICALLY FRAGILE, TECHNOLOGY DEPENDENT OR HEAD INJURED AND IN NEED OF SPECIAL EDUCATION AND RELATED SERVICES.

ISSUE STATEMENT

Discretionary funds should be identified for the development and implementation of model/demonstration special education programs for medically fragile/technology dependent children and children with head trauma.

SPECIFIC RECOMMENDATION

Model demonstration and research projects for medically fragile, technology dependent and brain injured children should be included in all existing federally funded research and demonstration programs.

E. NASDSE/OSERS-OSEP INITIATIVE

1. PROVISION OF RELATED SERVICES.

ISSUE STATEMENT

It was assumed that the definition of related services in P.L. 94-142 regulations (Reg. 300.13) would be sufficient to determine what services may be required to assist a handicapped child to benefit from special education. Litigation history has demonstrated that more clarification is necessary.[1] Mechanisms should be developed to encourage agency collaboration in the provision of needed services to handicapped children. Also, the assignment of agency responsibilities in providing services continues to be troublesome in States.

SPECIFIC RECOMMENDATIONS FOR ACTION

1. NASDSE will appoint a study committee to identify potential solutions to the problem, including recommendations for Interagency Agreements (with federally funded agencies operating in states), which would increase the amount of services available for handicapped children, reduce educational costs of services, or increase resources available to education agencies for providing services.

John F. Allan
Assistant Commissioner

Division of
Special Education

DEPARTMENT OF ELEMENTARY & SECONDARY EDUCATION
P.O. Box 480
Jefferson City, Missouri 65102

February 11, 1986

Dr. William Schipper, Associate Director
National Association of State Directors
 of Special Education, Inc.
2021 K Street, N.W., Suite 315
Washington, D. C. 20006

Dear Skipper:

You asked that I submit some information of our support for changing the provisions of the EHA regulations regarding nonsupplanting. This has been a very difficult area for us to address in Missouri but I feel that the problem is not unique to Missouri and it is probably being experienced by several other states.

The problem, as we see it, is the language for "nonsupplanting," Section 300.230. We have no quarrel with the first section (A) as it speaks about the use of funds to supplement and to the extent practicable increase the level of state and local funds expended for the education of handicapped children and in no case supplant both state and local funds. The problem is in section B which tells the procedure to meet the requirement of paragraph A of this section. The regulation indicates that "(1) The total amount or average per capita amount of state and local school funds budgeted by the local education agency for expenditures in the current fiscal year for the education of handicapped children must be at least equal to the total amount or average per capita amount of state and local school funds actually expended for the education of handicapped children in the most recent preceding fiscal year and for which information is available. Allowance may be made for: (i) decreases in enrollment of handicapped children; and (ii) unusually large amount of funds expended for such long term purposes as the acquisition of equipment and the construction of school facilities; and (2) the local education agency must not use Part B funds to displace state or local funds for any particular cost."

The problem that we have been experiencing is that the language in B reads the same as directions for maintaining local effort. We have been interpreting this requirement as a maintenance of effort requirement even though it is included in the nonsupplanting section of the law. It was interesting to note that when the Special School District of St. Louis County was audited by the Office of Inspector General, they cited the district as in noncompliance on this part basically due to failure to maintain local effort, the assumption being that this resulted in a supplanting posture for the district.

We feel that an appropriate way to resolve the issue would be to adopt language similar to that which has been adopted for maintenance of effort procedures for Chapter 1. Under Chapter 1, section 558(a) they allow that "a local education agency may receive funds under this Chapter for any fiscal year only if the state educational agency finds that either a combined fiscal effort per student or the aggregate expenditures of the agency and the state with respect to provision of free public education by that agency for the preceding fiscal year was not less than 90 per centum continuing of such combined fiscal effort or aggregate expenditures for the second preceding fiscal year."

This section goes on to describe the procedure whereby the state education agency shall reduce the amount of allocation of funds in any fiscal year in exact proportion to which a local agency fails to meet the requirement of the 90 per centum of both the combined fiscal effort per student and aggregate expenditures. This procedure would be more equitable to administer in the event a school district does not come within the 90 per centum allowance, it would result in a reduction in the amount of available federal funds through PL 94-142 but would not cause a complete cessation of funding until the district is able to maintain the effort. I presume the reason behind that is that the reduction of funds would be made up of state and/or local funds during the year of penalty and thus would actually increase their level of state and local support during that current year. Chapter 1 also goes on to provide ability for the state education agency rather than the Secretary to waive the maintenance of effort requirement for one fiscal year if the state determines that a waiver would be equitable due to an exception or uncontrollable circumstances. This waiver may be helpful but we feel that the changes of the methods of calculating maintenance of effort is more pressing and is one that we could live without.

We have had several instances in the state whereby school districts have been placed in difficult situations due to our lack of flexibility in administering this supplant/maintenance of effort requirement. For example, we have become aware of two or three of our smaller school districts whose total Special Education program may include only a teacher for the educable mentally retarded and a speech therapist. In two of these situations the speech correction teacher resigned at the end of the year and moved on to another district. This district was unable to locate and employ a certified speech teacher and opted to initiate a contract with a neighboring district to serve the speech handicapped students. The end result was that the approximately $14,000 - $15,000 salary that was paid to the teacher during the preceding year was not offset by the amount to be paid for contractual services during the current year. The end result was that the students received the appropriate services but the district was found to be in noncompliance due to the fact that they had not maintained fiscal effort from the preceding year.

Another example was an instance where through our monitoring process we made recommendations that the district was probably overstaffed. It was our recommendation that through the reevaluation of some of the youngsters that the number of staff which they presently employed was not required. The district, following our leadership, reduced their number of Special Education staff by one or two teachers. The following year when the maintenance of effort was calculated, it was found that with this reduction they were in noncompliance for maintenance of fiscal effort.

A third example is the Special School District of St. Louis County and, as you know, one of our large school districts. They have not completely worked out their total problem. Their problem was that through some unfortunate management decisions over a two or three year period they were operating in a deficit mode. This was made possible as the district was using a $17,000,000 to $18,000,000 balance that had accumulated during the "good years." As in each of our budgets, it is impossible to continue operating when there is a greater amount being expended than is coming in and as you can guess, there was a "day of reckoning." The district during the current year will probably fall $4,000,000 short of maintaining effort. The district, over the past two years, has been forced to lay off a significant number of staff and support people. The basic programs to the handicapped youngsters remain untouched but several of the administrative staff and aide positions, as well as some of their attendants on their transportation routes, have been deleted due to this reduction in staff which was necessitated by their living within the amounts of revenue generated has caused this district to be in serious jeopardy of noncompliance.

The Special School District has been in contact with several members of the Missouri delegation in Washington. It is our understanding that they are attempting to get special dispensation from the U. S. Office due to the fact that they are a unique district and have been experiencing unique problems. Our staff feels that the approach of amending the regulations would be a much more viable solution and one that would not require a great amount of change in the legislation, if any.

I appreciate this opportunity to present the problems to you and offer a solution that we think would be viable. Please let me know if I can provide further information. I am looking forward to having the opportunity to visit with other NASDSE members regarding this proposal. We certainly appreciate any help that you or other NASDSE staff members can provide as it is a situation that needs to be addressed as it may be having a negative effect on the services to handicapped children.

Best regards.

Sincerely,

John Allan

John F. Allan
Assistant Commissioner

oe
cc: Dr. Samuel Scarnato
Dr. Arthur L. Mallory
Mr. Bill Wasson
Dr. John Heskett

ACTION
AGENDA

E. NASDSE/OSERS-OSEP INITIATIVE

2. NONSUPPLANT REQUIREMENTS. (Reg. 300.230)

ISSUE STATEMENT

The current nonsupplanting requirements in P.L. 94-142 regulations make allowance only for (i) decreases in enrollments and (ii) large acquisition of equipment and construction. Flexibility as contained in other Federal programs is necessary.

DISCUSSION/CLARIFICATION

(examples of this problem are attached)

SPECIFIC RECOMMENDATIONS FOR ACTION

1. NASDSE will compile examples of problems caused SEAs by current law/regulations.

2. NASDSE will advocate for amendments to Law and/or regulations which will provide flexibility in the supplant requirements.

E. NASDSE/OSERS INITIATIVE

3. INSERVICE TRAINING: NEW TECHNOLOGIES.

ISSUE STATEMENT

Computers, assistive devices, and software have the potential for increasing the independence, productivity and well being of handicapped children and adults.

The new technologies must become truly effective tools for learning and work. Classroom teachers and other professionals need access to inservice training on the new technologies, curriculum materials, and management techniques to ensure efficient and effective use of the new technologies.

Increased discretionary funds (Part D) need to be available to state and local school districts to develop and implement training programs and procedures to effectively integrate the new technologies into the curriculum and classroom activities.

SPECIFIC RECOMMENDATIONS FOR ACTION

1. NASDSE will advocate for new legislation or regulation to establish a grants program to SEAs to assist them in providing inservice training of teachers and administrators of special education programs in ways to use the new technologies.

2. NASDSE will study the possibility of including in the Part D program targeted grants to SEAs for providing inservice training in ways to use these new technologies.

E. NASDSE/OSERS-OSEP INITIATIVE

4. INSERVICE TRAINING: SCHOOL BUILDING SUPPORT TEAMS.

ISSUE STATEMENT

Training funds need to be available to assist school districts to develop teacher assistance teams at the building level. Leadership and funding for this initiative should be provided by Elementary and Secondary Education.

These teams, composed of regular education teachers chaired by the building administrator, are convened to develop alternative educational strategies for children experiencing learning difficulties. Data currently available shows dramatic reductions in referrals for evaluations for special education where such teams are in place. Further, opportunities for handicapped children to participate in the regular education environment is greatly increased.

SPECIFIC RECOMMENDATIONS FOR ACTION

1. NASDSE will advocate for new authority in legislation or regulation to establish a grants program to SEAs to assist them in developing teacher assistance teams at the building level.

2. NASDSE will study the possibility of including in the Part D program targeted grants to SEAs for developing teacher assistance teams.

Mr. **Williams**. Thank you very much, Mr. New.

Let's proceed now to questions from members of the committee. Mr. Bartlett.

Mr. **Bartlett**. Thank you, Mr. Chairman.

Mr. Chairman and witnesses, I have about 6 hours' worth of questions, but I will try to confine, at least for the first round, into 5 minutes. Let me start first with a general question and then try to move into some specific questions, and invite each of you to give additional specifics that you think we need to know.

I am trying to decide how to phrase this question, so let me just sort of clumsily wade into it. From reading the written testimony and from hearing your testimony, with varying degrees, your organizations have some serious reservations about many of the specifics of S. 2294, and some very specific suggestions for improving it. But it sounds as if you are ways apart, as far as we have a way to go, to make the legislation a piece of legislation that will accomplish the objectives.

I suppose my first question is, is that a correct characterization, or how would you redefine—I didn't hear, for example, the State legislature's comments as to whether you support, or oppose the bill. I saw 10 recommendations of specific changes in the special education, and then you have—is it a long list, or a short list, of other things that you just haven't reached a consensus as to how you would change, or not.

The CEC, I thought, had a very well presented testimony, presenting both the good and the bad. Did you tell the Senate this, as they were developing the legislation they sent over and urged us to rush through in two days?

Mr. **Weintraub**. Yes. As far as the Council for Exceptional Children is concerned, I don't think that the concerns that we are expressing are new concerns, they have been expressed and communicated with the Senate.

I would want to make a distinction, and I will leave to my colleagues the accuracy of the impression. I think what I am hearing, both from our membership and from other organizations, and people around the country is that this is a job that is long overdue. I would mention that I had this opportunity to testify on this issue before this committee in 1969. This is not a new issue. In fact, this body passed this mandate before the Senate dropped it out of 94-142. So, this body has been an advocate for this issue. So, I think that's one.

The second point is that I think that what is needed to be done is cleaned up. I am not hearing people talk about the basic concepts or construct that the Senate bill is bad, or basic fundamental work needs to be done. There are a variety of technical things that need to be done to make it a more workable piece of legislation. I think those are the issues that are being addressed.

My final point would be, I would be terribly disappointed, and perhaps surprised, if there is not a base for the consensus that the chairman talked about earlier not being possible on this. At least I think among the varying groups, I think there is the base for that consensus.

Ms. **Hanft**. I would like to support what CEC is saying, CCDD did work with the Senate people, we did provide detailed testimony to them which—some of the recommendations were included in amendments before the bill was passed.

We do feel very strongly that the basic concept of the earlier portion, in that we are looking at a wide variety of services that need to be provided by many different agencies, that is a basic concept that needs to be built around. We are highly supportive of that.

We tried to make our testimony as detailed as possible, to try and make it flow through. But the great proportion of what is being recommended and proposed, we are in support of, particularly for the early intervention portions.

We do think that one of the recommendations we have, and that we would still like to see is that parental participation in the Early Intervention Council be strengthened. We feel that it is vital that parents have a chance to provide their perspective to the workings of the programs, since the services are really intended for them and their infants.

Mr. VICKERS. Let me clarify, if I left any misunderstanding. We do support the bill, and let me give you two answers. One resresenting the National Conference of State Legislatures, we support the bill; one from the perspective of a State senator from Nebraska, a State that already provides the services from birth. We support the bill, from Nebraska's point of view, very much. Pass the bill, but please send money.

The concern that we have tried to raise is because of our experience, we understand the costs, we understand what may happen in terms of the growth of the program, we think it is important. We are committed to do it, but we also understand the fiscal problems that a government has, and that the States have. So, do it, but send money along at the same time.

Mr. NEW. I think I will just echo all of those comments. As I indicated, a number of the principles that we have set out in the beginning would support S. 2294. There is always place to make improvements, some of the issues that we attempt to have improved, as it was going through the Senate, there were some compromises made. We would still believe that it would be improved, had some of our points stayed in, but I don't think that it is going to be impossible to identify a consensus and put together a bill that would gain the support.

Mr. BARTLETT. How would each of you address the definition of the zero through two developmentally disabled? Would you leave it the way it is in the Senate bill?

I think the CEC testified that they would not, that you would change it. I wonder if you could give us some state-of-the-art as to what the appropriate definition would be?

Mr. WEINTRAUB. If I could ask Dr. Smith to respond to that.

Mr. WILLIAMS. Please identify yourself again for the record, Ma'am.

Dr. SMITH. I am Dr. Barbara Smith, I am a member for the Council for Exceptional Children, and active in the area of early childhood and early intervention, particularly in State policy.

Mr. WILLIAMS. Thank you.

Dr. SMITH. One of our positions—well, let me answer the state-of-the-art issue, the States that are currently mandating services down to birth have a variety of definitions for that age group.

Many States who do not mandate the services are providing the services. Again, they have a variety of definitions for the eligible population.

It is because of that—and I would like to reiterate Senator Vicker's comment that the States really have attempted to do quite a bit so far in this age group. I think that all of us in the field feel that we want to support what the States have started. The definition is one of those.

So, we are looking to as much discretion as reasonable in defining the eligible population. So, we would like to see, for instance, developmentally delayed maintained in the definition, but the word "significant" taken out, because we prefer to let the States decide what a significant delay is. Most of the States already do that, one way or another.

Again, we would like to see—we feel it very important to put high risk children as eligible populations in the birth to two. We would like to see the definition of who the States feel they want to service high risk, leave that up to the States.

So, in contrast to where we were when 94-142 came along, we feel that there is a good bit of state-of-the-art and the States have already begun in this area, and that State discretion be allowed.

Mr. **Bartlett**. So, you are testifying—let me see if I can characterize this, you are testifying to generally permit the States to set their own definition for 0 through 2?

Dr. **Smith**. Particularly their criteria for identifying those children. I think the definition now is pretty sufficient, if we took out the word "significant" before developmentally delayed, and if we added "high risk." I think the definition itself is pretty sufficient, but the criteria, how you test them, who tests them should be left up to the States.

Mr. **Bartlett**. Would you have that in the legislation, that it be left up to the States?

Dr. **Smith**. I think by omission it would be left up to the States.

Mr. **Bartlett**. You are a trusting soul.

Dr. **Smith**. If we look at some of the States, and I use Maine as an example, Maine is doing some very exciting things in terms, particularly, in rural areas, trying to reach out to kids who were born in circumstances that we would say, gee, they may not be handicapped today, but we know 2 years from now they are going to be. Maine is doing some very creative things, and a number of others are, as well.

Our concern is that whatever we come up with, not be regressive, or turn States back from doing more than what it is we are proposing. Sometimes Federal legislation is needed to encourage people to do it, sometimes Federal legislation should be careful that it doesn't discourage.

Mr. **Williams**. The gentleman's time has expired. If any of the other witnesses wish to answer Mr. Bartlett's question, please do so, briefly.

Ms. **Hanft**. Two quick things that I think CCDD would support, one is that the definition as it stands now really does not address the needs of the at-risk child, the child who is at high probability of developing a delay. Second, we think that there is a lot of research out there that shows that the earlier the intervention is started, the greater the savings in terms of just looking at education right now, not even looking at what happens with the families.

The definition as it stands now is very much open to interpretation, whether or not, if the child is not now showing substantial delay, is that child eligible for the program. We think those children need to have the services now, not wait until they are 3, 5, or 6.

Mr. WEINTRAUB. I would like to suggest that the Federal Government provide a broad guideline, in terms of definitions, so that all the States will know what the guidelines are, the general guidelines that they are operating under, and as to how you do that, I don't have any specific language for Congress.

In terms of giving States flexibility, I think if those guidelines are broad enough it will give the States the flexibility to meet the specific needs within those States.

As I indicated earlier, I would hope those guidelines are broad enough, so that those of us who have already moved in that direction, that our definition will fit within those broad guidelines.

Mr. BARTLETT. If the chairman would yield for a very quick follow-up question.

Mr. WILLIAMS. Yes.

Mr. BARTLETT. My question is does this bill do that, follow the broad guideline theory, or does it specify more narrow?

Senator VICKERS. I am probably not qualified to answer that, it would be better to get back to you later on.

Mr. NEW. Starting from the principle that we believe there ought to be sound public policy on services for all the young children, and focusing especially on handicapped children, we would believe that given a funding mechanism that is based on census data, that the States can define the population, that there are provisions for the council and duties of the council, the fact that it is a grant program, the fact that there would be data collected, there would be plenty of opportunity for the States then to define that population, target the groups that they would wish to encompass.

I would say, in terms of the bill, if you don't define it, then we get to define it. You could leave it as it is, and we will define substantially developmentally delayed.

Mr. BARTLETT. Thank you.

Mr. WILLIAMS. Mr. Biaggi.

Mr. BIAGGI. Thank you.

Ms. Hanft, the degree of cooperation between local, State and Federal agencies clearly, is going to be a significant situation. Does this legislation adequately address this need?

Ms. HANFT. I think, as I said before, that we see the merits of this bill in that it does have broad interagency kinds of services being offered. In order for the program to be really effective, there has to be some mechanism to bring these agencies together.

I think when we look at what is happening with 94-142 right now, all the responsibility lands on the State educational agency and services for this group has to be expanded beyond education.

I don't think right now, since my group, CCDD, believes that the Early Intervention Council is a real viable mechanism for promoting and developing these relationships, but as it stands now, the Council seems almost more in an advisory role.

We would like to see them given a clear mission to, not only promote the development, but to actually develop. This Council is a body that sits down and knocks out the agreements, and works out, specifically, how different portions are going to be put together, what the agencies are going to contribute, as far as fiscal responsibility, that kind of thing.

The Early Intervention Council also has to represent what the parents and what the families feel. We are concerned that having professionals and State bureaucrats, even though a lot of these people are parents, they may not be a parent who has had to live through having a handicapped child. We feel that parental perspective is important to represent on the Council, also.

Mr. **Biaggi**. Well, my experience with 94-142 tells me that parents, for the most part, are real experts in this area, and you are telling me that that is not universal.

Ms. **Hanft**. No, I think that parents are the experts, and as the bill stands now, I don't think that mandated parental slots is there, and I think it needs to be there. I think that the parents—when you live through having a son, or a daughter that has a problem, you have a totally different perspective on what you need in order to survive, and what your son or daughter needs.

I think that because parents have that perspective, they should be included in helping to promote what kinds of services does this State need to provide to help the children.

Mr. **Biaggi**. Elaborate some on the statement you made, under 94-142 the burden rests with education, is it your suggestion that it have education as the lead agency?

Ms. **Hanft**. That is really something that can be left up to the State. The concept of a lead agency, I think, is important, to follow through with what kinds of agreements the Early Intervention Council comes up with.

The point I was making was that right now we have a system that when parents are unhappy, or services aren't being provided the way they want there is established, one agency to go to, to either say we need more services, or we are not happy with what is going on and define responsibility in terms of who ultimately has to provide the services. We are talking about a whole new system right now, and we are talking about services that in a lot of States these agencies haven't worked together. So, that is important to pull that together, and I think the fact that we are creating that new system mandates that we have another way of looking at how we are going to pull together these people to be working.

To me, in this bill, and I think CCDD—I am representing what their thinking is that this whole interagency concept is the focal point of services for early intervention, but it also can be the downfall if we don't have a system to really pull the people together.

Mr. **Biaggi**. What would it require?

Ms. **Hanft**. As I said, I think they have to have more authority, clear authority to develop agreements.

Mr. **Biaggi**. Who needs more authority?

Ms. **Hanft**. The Early Intervention Council.

Mr. **Biaggi**. That would be the mechanism?

Ms. **Hanft**. That would be a mechanism to make that real strong. And, also, I think because we are talking about transitions, from 0 through 2, to school age, say at 3, if the mandate goes through, the State education agency is a real vital player, I think they should be mandated to sit on the Council, as well as what is in the bill now, that every agency that is involved providing services to children.

Mr. **Biaggi**. Mr. Weintraub, you discussed the issue of the at-risk population. How would you define who is at-risk? How would you relate the importance of those services to this population with respect to the bill as a whole?

Mr. **Weintraub**. Well, when one looks at the question of at-risk kids, fundamentally there are—at least professionally looked at, there are three groups of children. We have children who are handicapped, who we know are at-risk; when we look at infants, that is a relatively small group because it is only a group that we can see. It tends to be kids that have clearly a physical disability of some sort, or clearly some genetic problem, but something that is clearly observable.

The second group of kids are the kinds of kids that we talk about as being biologically at-risk, there is something in their biological system, or in their whole composition that says that yes, they may not be disabled today, or developmentally delayed today, but information tells us that if we don't do something, that before long they will be.

Then there is a third group of children, which is the larger group, which we talk about as the environmentally at-risk, simply children who live in poverty and live in a variety of situations that suggest that they may be faced with problems in the future.

How broadly one approaches the at-risk question is, I think, a political judgment, as to how the population, because certainly you move across those three variables, you increase the size or number of children you are talking about.

We, at least feel in the first two groups, that the bill primarily addresses the first group. We believe, at a minimum, the second group ought to be addressed, and we would certainly not want to interfere with the States and those who are actively working on including the third group, as well. We think it is possible to come up with some functional definitions. We would use the example from the State of Texas, and others—Louisiana and others that are doing some very positive things in this regard, and we think there are clearly ways of addressing that issue.

Mr. **Biaggi**. Do you think it is critical to have it included in this bill?

Mr. **Weintraub**. I think it would be a serious error to not include it. Again, we would emphasize from the point of if we don't do it, we are going to have kids—if one of the things is, as you indicated in your opening statement, Mr. Biaggi, if we do this stuff now, we save lives, we save children and we save money—we do all of those things. To simply arbitrarily exclude a group of children who could benefit from the same services, et cetera, for the sake of some pure definition, and as a result eliminate a bunch of children who we could help and prevent from having to go into special education later, makes an awful lot of sense.

Second, I think the state of the practice in the field is a lot better than we often give it credit for, and we would hate to see Federal policy restrict better behavior.

Mr. **Biaggi**. I would like to make a realistic assessment of the situation, given that there is a general acceptance of the notion of early intervention at earlier years, also given the projected costs of this program in this day and age of budget deficit, what do you think the prospects are?

Mr. **Weintraub**. For passage, or for money?

Mr. **Biaggi**. For money.

Mr. **Weintraub**. Again, I would want to make a distinction between the birth through 2 population, and the 3 to 5. If what we are talking about, and I think when we talk about the high risk we are really talking about the birth to 2, the critical factor, and I think in the decisions that you have to make fiscally is not how much new dollars you put out there. Senator Weicker is talking about $100 million, $100 million might be good money in all of this, the critical factor is whether programs like EPSDT, Medicaid, Medicare, varying private health insurance, and all of those programs run away.

If those run away, we are dead and we have hurt children. If what we do is provide for the effective case management and the coordination of those programs, then that $100 million would be very well spent, and we believe we would serve an awful lot of kids. But I think we need to make a decision.

I don't think we can fiscally afford to talk about putting the dollars out to serve all of the kids. We have got to depend upon the resources that are out there. It is our belief that a significant portion of the resources are already there for that population; the 3 to 5 issue is a different one.

Mr. **Biaggi**. If we do it that way, the prospects of those other agencies running away are nullified?

Mr. **Weintraub**. If we do it carefully, yes. I guess our concern is we are not sure that the Senate bill is careful enough.

Mr. **Biaggi**. I think that is a critical point. Thank you.

Thank you, Mr. Chairman.

Mr. **Williams**. Mr. Hayes.

Mr. **Hayes**. I apologize, Mr. Chairman, for having to run out to another committee meeting. I will be very, very brief. I don't want anybody confused by thinking of me as a fiscal conservative. I just want to be cautious as to how we spend our money, and sort of prioritize spending the dollars.

My colleague from Texas, I think, would fit that mold much better than I will. But I am concerned, Ms. Hanft, you raised the question of the Council on Early Intervention having its own funds. Could you elaborate on that a little?

Ms. **Hanft**. That recommendation comes from, again, our feeling that in order to bring together all these agencies, you need a strong body, and we see that as the Early Intervention Council. However, if they are being, as we are recommending, being asked to develop interagency agreements to see that the system provides the kinds of services for that State that is in need, we don't think they can do that, unless they have a budget and they have a staff.

We are talking about an individual from each public agency that is already providing services, we are talking about a representative of the Governor. We are talking about two additional people who could be parents right now, or professionals. They are going to need a budget to come together and oversee this.

I think having a budget and staff gives them some authority, beyond the mandate, to develop the agreements. Now, the question then comes up of how much, also, in terms of administration, and is the work of the Council considered part of the administration of this bill, there is a 10 percent set aside for administration.

We think that during the phase-in that a lot of what is going to be going on in the States could be defined as administration in terms of pulling together the programs and overseeing what is going on.

We are concerned that this cap be applied, particularly during the phase-in period, which we define until 1990. Having a percentage, trying to put a percentage on this now—we have been talking about this—it is difficult when we are not sure how much money is going to be appropriated in the end, in terms of the use of the federal funds.

Mr. Hayes. But you think this should be a part of the overall budget?

Ms. Hanft. Not separate, coming from another source, but as part of this.

Mr. Hayes. Local, State and Federal, moneys, or are you talking exclusively about Federal moneys?

Ms. Hanft. I think a portion of the Federal moneys need to be appropriated that way.

Mr. Hayes. Mr. Vickers, you mentioned the question of costs, too, several times in your testimony before I left. I do hope that with your experience in working with the committee, you will be able to use some influence over some of the representatives from your great State of Nebraska, and have them support the financing of this kind of program.

Am I on the right track when I say that?

Senator Vickers. You can be assured that they will be contacted. I cannot guarantee how they will come out on it. But I would like to give you some indication of the costs, the way they are divided in Nebraska right now.

The Federal Government provides about 10 percent of our total cost of our special education program; our State provides 90 percent of the cost above that. So, the locals put in less than 10 percent of the cost for the program.

In terms of coordination, that is a vital point, it is one of the ones that we really had to make sure that we were doing a good job in Nebraska, and I agree with the other panel members that there are a lot of other sources with funds already out there for the preschool children but you need to be certain that the coordination of those activities are there, so that those agencies are involved.

One final point, I think it is appropriate—the question has been raised a number of times in Nebraska, and I am sure in other places as well, is which agency should be in charge, and is it really the duty of the schools to provide services from birth, which in terms of access to the parents, the schools are much more accessible than any other agency of government, at least in our State. So, it became very apparent that the schools were the appropriate agency to charge or the lead agency, if you will. Since 1978 it has worked remarkably well for us.

Mr. **Hayes**. Thank you, Mr. Chairman.

Mr. **Williams**. Let me ask each of you about the cost of these recommendations that the 3 to 5 mandate be made an entitlement with a pre-determined funding level established by the Congress. CBO in its cost estimate of mandating 3 to 5, indicated that in the year 1990 the costs could be $2,700,000,000.

With that in mind, what about making this an entitlement to the pre-determined share guaranteed from the Federal level?

Mr. Weintraub, why don't you go first?

Mr. **Weinbtaub**. I think it is a peachy idea. I think those of us who work up here and have to annually fight with the appropriations committees would think that an entitlement is an absolutely heaven-sent phenomena.

Mr. **Biaggi**. Entitlements are an endangered species.

Mr. **Weintraub**. That's right. I think certainly the question becomes one of—let me respond to it. An entitlement would certainly be helpful, I think, to ensure that we are going to have the dollars, and that the Federal commitment is there.

I would want to be careful in saying, at least from our posture, we wouldn't make the question of whether this bill should be passed, or not, conditioned on the question of whether there is an entitlement.

Mr. **Williams**. Would, or would not?

Mr. **Weintraub**. We would not want to say that. We would certainly put all our energies in support of an entitlement, but we don't think that the question about whether we should do this, or shouldn't do this would be hostage to the question of an entitlement.

I think one of the things we also need to be careful about is our assumptions about the sums of money. We can show you figures that would suggest that we are talking about $200 million, and we can show you figures that suggest $2 billion. I think one of the things that we all need to look at are the projected census of birth rate and those kinds of things, what they are going to be over time.

But I am not as sure that the—the $2 billion figure sounds a little high to me.

Mr. **Williams**. Ms. Hanft.

Ms. **Hanft**. We are recommending that the 3 to 5 services and funding be folded into 94-142 in total, so that you have a range of services from 3 through 21. I think to treat—there is a problem with treating the 3 to 5 year population differently, looking at the funding, with regards to how would that play out with the services, specifically pinpointing this population. I think that it is important that these children, we are saying up front, they are entering the education system at age 3, and I think the special education and related services that are in place now should be available to them, not any more or any less.

Mr. **Williams**. Senator.

Senator **Vickers**. We are a little bit nervous about entitlements. Personally, I would prefer, as Barbara just mentioned, that the funds be included in part of 94-142, especially for those States who have already got the program in place. I would urge you to also make certain that the planning legislation doesn't apply to preschool programs, so those who have already developed a full array of programs will be able to use whatever funds there are for those programs, instead of having to develop new ones.

The planning provision could be a problem for those of us, if it applies to preschool education.

Mr. **Williams**. Mr. New.

Mr. **New**. The concept of the trigger mechanism, meaning one that at this level of funding a clock starts, we would say that the 1.3 level, as a trigger mechanism to start the clock between now and 1990 would be an appropriate way to start. However, we would like to see a trigger figure at each year, to 1990, with 1990 recognizing full Federal partnership, representing 40 percent of the national average costs, and build that in a year at a time, knowing that should it not occur, then you have just taken your finger off the trigger.

Mr. **Williams**. Mr. Weintraub, I want to comment on your, in my judgment, excellent description of the difficulty that this population faces when the nonschool based resources continue to disappear. Your suggestion that every effort needs to be made by this committee and the Congress, and the administration to prevent that from happening.

We pretend to replace those services, sometimes when, in fact, we are not. It seems to me that we do need an annual, or perhaps every 2 year state of the disabled services report that comes to the Congress, and to the administration. I intend to try to act, and hope that my colleagues on both sides will join in that effort, because we do need to have a better sense of which services might be disappearing as we move ahead.

Well, our thanks to this panel. You have been very helpful, and we appreciate your efforts to prepare your testimony and to be with us today.

Thank you.

Our second panel is Mr. Don Sheldon, Ms. Carol Reedstrom, Mr. Gary Timmons, Alicia Smith. If you will please come to the witness table.

Again, we want to encourage you to stay within, as close as you can, our time limit. We are running a little behind our scheduled time, and each of the members have other also important matters to which we must attend.

Don Sheldon is the Deputy Director of the American Association of School Administrators and is here representing that association.

Mr. Sheldon, please proceed.

STATEMENT OF DON SHELDON, DEPUTY DIRECTOR, AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS, REPRESENTING THE AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

Mr. **Sheldon**. Good morning, Mr. Chairman, members of the panel. My name is Don Sheldon, I am Deputy Executive Director of the American Association of School Administrators, a professional organization of some 17,000 educational leaders from across this country.

I am going to depart from the text that you have before you, and that was entered into the record, or will be entered into the record. And in the interest of time, offer a few extra or additional comments by way of amplification.

We do support and strongly so the concept of early intervention. We have supported, and were instrumental in the implementation of Public Law 94-142. We have seen the impact of that legislation on the education of children throughout this country, the record is quite clear, it has worked. Early intervention is something to which we subscribe without qualification.

The program, the 94-142 program has had a dramatic impact on the lives of countless millions of children, I suspect, since its inception. Children who now have been able to take an appropriate place in society, one that would not have been possible for them, without the assistance provided through Public Law 94-142 and related activities.

Thus, we understand certainly the need for appropriate early intervention for children of special need. As a matter of record, however, I would state that we are concerned about any legislative provision which would mandate services for children ages 3 through 5, not because of any insensitivity certainly to the needs of those children, but because of an awareness that school districts throughout this nation are already very heavily burdened.

The resources are taxed to the very limit in the provision of services that are now found to be very necessary, and even so in some cases wanting.

The present commitment to the provision of programs and services to children under P.L 94-142, one for example, in 1979 was supported by Federal funds at a 12.5 percent level, that figure reflected as a percentage of the cost of educating a special ed child is a level that has declined consistently over the course of the years. While the level we suggest was dropping, the number of students being served under the banner of 94-142 were increasing.

The number of students now in that category is approximately 4.1 million. The authorized funding level of today, if the Gramm-Rudman-Hollings cut is not considered, stands at 40 percent. A level of funding, I would submit, that is unattainable, especially given the budget crunch that we are facing now, and certainly when one looks at the funded level for 1986 of 8.6 percent, roughly $275 per student, which falls far below the cost of educating a special ed child in any State.

The costs of the program are subject to debate. I think that there are numbers that can be generated from a variety of sources, and you will find some discrepancies, certainly, in these numbers. Yet, I think we all can agree that the cost would be significant.

Mr. Chairman and subcommittee members, we stand as advocates for all children. We recognize the at-risk youth. My definition of at-risk youth might expand somewhat upon that used by Mr. Weintraub, but we are in basic agreement. As advocates for all children, we cannot support any mandate, any expanded mandate for the provision of services to a segment of the student population, unless the funds follow. It is as simple as that for us.

It is a serious problem in the public schools of this country. A mandate without funding would mean without any doubt an erosion of existing services in many districts, if not most; perhaps eroding services now provided for the disadvantaged youngsters.

Our request and our proposal, Mr. Chairman, is that, one, the handicapped education services for those in the 3 through 5 age bracket be enacted as an entitlement program, and, two, that an entitlement program be established to assist those States opting to serve handicapped children from birth through age 2.

Again, by way of repetition, but for the sake of emphasis, we believe that the programs in the public schools of this nation will be seriously hampered, if there were now imposed upon them an additional mandate to provide services without the funding. Public Law 94-142 has been a part of the national education agenda for a long time, but since 1983, we have seen the national agenda for education expanded. We are called upon to provide better services, and in some instances, more services, but utilizing available resources, existing resources.

So I submit they have been taxed, the public school districts cannot absorb additional burdens.

I thank you for your attention.

[The prepared statement of Don P. Sheldon follows:]

STATEMENT OF

DON P. SHELDON

DEPUTY EXECUTIVE DIRECTOR

AMERICAN ASSOCIATION OF SCHOOL ADMINISTRATORS

ON

S.2294, THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

JULY 23, 1986

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

Mr. Chairman and members of the subcommittee, I would like to thank you for giving school administrators the opportunity to testify before you on S.2294, the Education of the Handicapped Amendments of 1986.

My name is Don Sheldon. I am deputy executive director of the American Association of School Administrators, the organization which represents more than 17,000 school executives across the nation.

As the educational leaders in our communities, we are strong supporters of P.L. 94-142. We have seen firsthand evidence of its impact on the lives of handicapped young people. We have helped preside over a program that lifts up young lives and offers hope for a better future to those who just a few years ago had little hope at all for a productive life.

In addition, we acknowledge with the sponsors of S.2294 the tremendous benefits that accrue to handicapped younsters who are identified and begin to receive handicapped education services in the first few years of life. We commend this committee and Congress for adopting preschool incentive grants to encourage delivery of services in those critical first years.

The evidence is clear that we must act early. Numerous studies mentioned in the Education Department's annual report to Congress have cited the benefits of early intervention. The move in S.2294 to develop a discretionary program for infant intervention is logical and is consistent with the incentive grant program in current law. It would seem to provide the kind of encouragement that will lead more states to take action to fund early childhood services.

The part of the legislation that causes us concern, however, is the provision that 94-142 services be mandated for children ages three through five. It concerns us, Mr.Chairman, not because we fail to see the worth of such services, but because school districts are reeling under increased demands for regular 94-142 services in the face of a declining federal financial commitment that falls far short of the funding levels envisioned in the original 94-142.

The number of children receiving handicapped education services under this law has grown steadily from 3.485 million in 1977 to approximately 4.15 million today. Federal funding, on the other hand, expressed as a percentage of the average per pupil expenditure for handicapped children, peaked at 12.5 percent in 1979. In that same year the program's authorized level, which we fully expected to receive to help us carry out this worthwhile but costly national mandate, was 20 percent.

In 1980 the program was allotted enough money to fund just 12 percent of average per pupil costs, while the authorized level in the law climbed to 30 percent. And in ~~1980~~ 1981, when P.L. 94-142 was to reach the peak authorized funding level of 40 percent of per pupil expenditures, appropriations in Congress were frozen and as a result just 10 percent of average per pupil expenditures were met with federal funds.

Today, if we ignore the March 1, 1986, Gramm/Rudman/Hollings cut, the authorized level still stands at 40 percent, and it seems all the more unattainable because the actual funded level for 1986 is only 8.6 percent. That's a mere $276 per student from an appropriation that sounds impressive--at $1.135 billion--but that pales in comparison to $23.6 billion, which was the Rand Corporation's estimate of the total cost in 1982-83 of educating handicapped children in the 94-142 Part B state grant program. And we know those total costs have only gone up over the intervening three years.

We realize you are the authorizing committee, Mr. Chairman, that you have no control over the level of appropriations proposed by the appropriations committees and finally adopted by Congress. Those committees look upon Public Law 94-142's 40 percent funding level as a suggestion, not a mandate. While those of us charged with providing education and meeting the bottom line see a clear and unambiguous mandate in the provisions of 94-142.

As a result, our position must be clear. We simply cannot accept a new and expanded mandate for handicapped education without the money to pay for it. Because such a mandate, in the face of a real decline in federal support and an equally likely real decline at the state and local level for all of education, will only mean a reduction in services to children somewhere else in the system.

What, then, is the answer? We all see the value of early intervention, both for children and for society, but acknowledge that we have more than we can deal with under the current law.

We would propose, Mr. Chairman, that you take the step that must be taken. That handicapped education services for those in the critical 3 to 5 preschool years be enacted as an entitlement program.

Certainly we recognize that all of 94-142 could not be adopted as an entitlement at this time. With approximately 10 percent of the school-age population now identified as eligible for 94-142 services, it is an enormous struggle each year just to keep from slipping further back, in real terms, from the level of appropriations handicapped education received each preceding year. But establishing entitlement services for the much smaller age range of 3 to 5 years would be far less expensive for the federal budget, since only 5 to 8 percent of that age group is estimated to be eligible for the proposed services. And focusing entitlement resources on that age group would be tremendously cost effective for all of us.

And, frankly Mr. Chairman, only the federal government has the resources to carry out this ambitious mandate. Of course, we realize that Congress and the nation are facing budget difficulties. But federal funding for elementary and secondary education has consistently dropped behind inflation each of the last three fiscal years, in the face of an expanding budget. According to the Administration's budget request, federal outlays for elementary and secondary education in FY 87 would have amounted to only 0.69 percent of total federal outlays. And that would have been down from 0.76 percent in FY 86 and 0.80 percent in FY 85.

The federal government--through its annual appropriations--

is spending precious little of its resources on education. So there's no reason this committee should feel awkward about approaching the appropriations committee with an entitlement for preschool handicapped services. Passage of such an entitlement would avoid an annual appropriations battle over this new initiative and would ensure adequate service to handicapped children without reducing services to other children.

States and local education agencies, on the other hand, can barely keep up with the demands on their services, and new state and local revenues--in states where new revenues are possible--to fund education at any level are not keeping up with expenditures in other service areas of government. Further, according to Census Bureau reports on governmental finances from 1979-80 through 1983-84, the elementary and secondary education share of total state and local spending has dropped from 21.9 percent in 1979-80 to 20.2 percent in 1983-84, the most recent year for which data are available.

The Congressional Research Service reports that handicapped education services from age three are currently mandated by only 15 of the 57 states and territories. Ten mandate services from birth, one from age 2, and 4 from age 4. A new mandate thus would have a wide range of impacts on states and local districts. Because some states are already moving ahead to provide varying degrees of preschool services for the handicapped, we would propose the federal government share a significant portion, but not necessarily all, of preschool handicapped costs through an entitlement. We believe an appropriate federal share can be negotiated.

We would further propose, Mr. Chairman that an additional entitlement be provided to pay handicapped education services from birth to age 2 in those states which have opted, or do opt in the future, to serve children from birth.

To sum up, the American Association of School Administrators:

1. Supports in concept the initiative for early childhood education services for the handicapped,

2. Recommends that the mandate for 3 to 5 year-olds in S.2294 be made into an entitlement for a significant portion of the average per pupil costs associated with the mandate, and

3. Recommends that an entitlement program be established to assist states which opt to serve handicapped children from birth through age 2.

We urge you to look closely at our suggestions, Mr. Chairman. An entitlement would assure delivery of services to those handicapped young people who desperately need our help. A mandate without the entitlement would not necessarily guarantee those services and would severely harm our efforts across the board at the state and local level.

Thank you, again, for taking the time to consider our views and for thoroughly studying and perfecting what could be one of the most significant pieces of education legislation to be enacted by Congress in many years.

Mr. **Williams**. Thank you very much, Mr. Sheldon.

Carol Reedstrom is a parent from South Dakota, a State with which I am familiar, being a neighbor of yours. She is here representing the Association for Retarded Citizens.

It is nice to see you here today, and please proceed.

STATEMENT OF CAROL REEDSTROM, PARENT, HURON, SD, REPRESENTING THE ASSOCIATION FOR RETARDED CITIZENS

Ms. **Reedstrom**. Thank you, Mr. Chairman, and members of the subcommittee, my name is Carol Reedstrom. I recognize the unique opportunity that I have, as a parent today, to represent the 160,000 members of the Association for Retarded Citizens, most of whom are parents of individuals with mental retardation.

My brief testimony today will be followed by a more extensive written statement which we hope will be made part of the hearing record.

Before I get into the specifics of the legislation under consideration, I would like to take 2 minutes to tell you about my child, Victoria, and how fortunate she is because she has profited from the early intervention services since shortly after she was born.

My husband, Dave and I have three children, ages 6, 4 and 8 months. Our first child, Victoria, was born with two birth defects, one being Down syndrome which is a genetic chromosome abnormality often resulting in some degree of mental retardation. The second defect is congential heart disease.

In a span of 5 years Vicki has had 31 hospitalizations, including 2 strokes, a pacemaker implant, numerous pneumonias, the open heart surgeries—we know we have more hospitalizations in the future. But you know, in spite of all of these setbacks, Vicki will be attending regular kindergarten this fall, and for that I am very proud and very fortunate. We would not have done that on our own, without her early intervention services. Her school day will be divided between regular classroom studies, including math, reading, language, writing skills—the same that all of the regular kindergarten kids will be getting, and they will be reinforced in the special education classroom. Without her preschool education experience, which helps both the parent and the child, she probably would not be starting school with children her own age.

Vicki was born in St. Paul, MN. She was diagnosed as having Down syndrome at 4 days old. Her pediatrician referred us that same day to the Association for Retarded Citizens for more information on mental retardation, as well as for parental support. It was the ARC who referred Victoria to a Developmental Achievement Center where she started her first formal schooling. Vicki was 6 weeks old at the time.

I might add that as a parent going through the emotional crisis that you have at that time of diagnosis, and basically you are in shock, you don't know where to turn, you don't know where to ask. If it hadn't been for the ARC, we would not have known about the Developmental Achievement Center, and she would not have gotten the start that she had.

The skills that a special education professional works on with a child as young as Vicki was at that time focus on the areas of gross motor development. A child with Down syndrome, for the most part, has no muscle tone. Therefore, simple tasks such as holding your head up, tracking objects with your eyes, reaching and grasping with your hands, things that you and I take for granted in ourselves, much less children, needed much extra stimulation and reinforcement for Vicki.

Once Vicki gained good physical endurance her teacher and therapist broadened her IEP, her individualized education program, to strengthen fine motor dexterity through occupational therapy. Since Vicki's verbal language was virtually nonexistent by the age of 2, we began to teach her sign language through speech therapy, and now my daughter is considered bilingual. She communicates with people who are hearing impaired, as well as those who are verbal.

Parenting is the most important profession on Earth. Some people choose to become parents, and others become parents "by accident." I have that in quotes, because that is a term we all hear—it was an accident. Either way, the exception of those rare few who knowingly choose to adopt a child with a disability, no one wishes or desires to become a parent of a child with a disability, mental retardation, or any physical disability.

It has been my observation that our society offers very little support in the way of educating and training parents. It is just something that we are suppose to know. Well, parenting is demanding enough, and when you add the extra challenge of working with a child who happens to have a developmental disability, the pressures and demand and the work load all but double.

At this point I hope that you have a better concept as to why I consider parenting a profession. My husband and I have had no formal training or background, prior to our daughter's birth, in the field of developmental disabilities. While it still hasn't been a formal education or background, we feel that we have earned associate degrees in physical therapy, occupational therapy, and speech therapy, not to mention the health care profession—pediatric cardiology, neurology, radiology, internal medicine and I could go on with that list, also.

Experts agree that the majority of mental and physical growth occurs in children during one's preschool years. With this in mind, the combination of an early intervention infant stimulation program and preschool training have enhanced my daughter's opportunities to become a productive, successful member of society when she becomes an adult. I have all of the confidence in the world that this is what her future will be.

Unfortunately, though there are thousands of infants and preschoolers in many States who are mentally retarded, who do not, and who will not in the foreseeable future have opportunities like Vicki has had. Our association last week conducted a phone survey of 20 State ARC chapters, from the 29 States not fully serving children below 4 years old, to ascertain those States' plans, as best as could be determined in regard to infant intervention and preschool services for children with disabilities.

The results of our survey indicate that 19 of the 20 States surveyed, whose current special education mandates starts at age 4, or above, are not planning to lower their mandate. Some of those

States have tried and failed to lower their State's special education law mandates and/or initiate early intervention services for infants with disabilities.

Clearly, parents in the significant proportion of our States, about one-half, have little, or no hope for their child to receive preschool or infant services. Yet we know how vital it is for them to receive for more independence. Since many of the States won't provide these desperately needed services themselves, we must look toward the Federal Government to provide that mandate. Our organization and others turned to Congress in the early 1970's to mandate special education. The Congress met that challenge in 1975, by enacting Public Law 94-142. Now, we turn to you again for more leadership. Early intervention and preschool services must be mandated by the Congress, if they are to become a reality in all States.

The Senate has provided you with a bill that must not be ignored, must not be held up until the next Congress. We strongly urge you to consider this vital legislation immediately. Again, thousands of infants with mental retardation and other disabilities are dependent upon you to move this bill in the House.

We recognize there are some difficult issues to be considered, and none of these are insurmountable if the Congress, the education community, and the disability community have the will to solve them. We have an opportunity today and for the remainder of this Congress to lower the special education mandate to provide early intervention services to infants that may not be available for decades.

On behalf of the thousands of parents of children like my daughter, I urge you, I implore you to place the highest priority on the passage of this legislation. The Association for Retarded Citizens stands ready to lend any amount of assistance necessary to work out an acceptable bill. We urge you to bring together the various parties to solve any difficulties surrounding this legislation. We can and must bring about legislation in this Congress.

The ARC commends you for holding these hearings and, again, the ARC and the Consortium for Citizens with Developmental Disabilities hope you will give the issues your prompt and full attention.

Thank you.

[The prepared statement of Carol Reedstrom follows:]

ORAL STATEMENT

of

THE ASSOCIATION FOR RETARDED CITIZENS OF THE UNITED STATES

on

S. 2294

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

PRESENTED AT

HEARINGS BEFORE

SUBCOMMITTEE ON SELECT EDUCATION

U.S. HOUSE OF REPRESENTATIVES

JULY 23, 1986

Presented by:
Carol Reedstrom

Mr. Chairman and Members of the Subcommittee, my name is Carol Reedstrom. I am pleased and honored to appear before you today on behalf of the 160,000 members of the Association for Retarded Citizens of the United States, most of whom are parents of individuals with mental retardation. My brief testimony today will be followed by a more extensive written statement which we hope will be made part of the hearing record. Before I get into the specifics of the legislation under consideration, I would like to take two minutes to tell you about my child, Vicki, and how fortunate she is because she has profited from early intervention services since shortly after she was born.

My husband and I have three children, ages 6, 4, and 8 months. Our first born, Victoria, was born with two birth defects. One being Down Syndrome which is a genetic chromosome abnormality resulting in some degree of mental retardation. The second defect is congenital heart disease. In a span of five years, Vicki had 31 hospitalizations including two open heart surgeries, a stroke, a pace maker implant, and numerous pneumonias. But, you know, Vicki is going to be attending regular kindergarten this fall. Her school day will be divided between regular classroom studies and math, reading, writing, and language skills which will be reinforced in a special education classroom. Without her preschool special education experience, which helps both the children and the parents, she probably would not be starting school with children her own age.

Vicki was born in St. Paul, Minnesota. She was diagnosed as having Down Syndrome at four days old. Her pediatrician referred us that same day to the Association for Retarded Citizens for more information on mental retardation as well as for parental support. It was the ARC who referred Victoria to a Developmental Achievement Center where she started her first formal schooling. Vicki was six weeks old at the time.

The skills that a special education professional works on with a child as young as Vicki focus on the area of gross motor development. A child with Down Syndrome, for the most part, has low muscle tone. Therefore, simple tasks such as holding your head up, tracking objects with your eyes as well as reaching, grasping with your hands - things that you and I take for granted - needed extra stimulation and reinforcement for Vicki. Once Vicki gained good physical endurance her teacher and therapists broadened her IEP (individualized education program) to strengthen fine motor dexterity through occupational therapy. Since Vicki's verbal language was virtually nonexistent by the age of two, we began to teach her sign language through speech therapy. Now our daughter is considered bilingual. She communicates with people who are hearing impaired as well as those who are verbal.

Parenting is the most important profession on earth. Some people choose to become parents. Others become parents "by accident." Either way, with the exception of those few who knowingly choose a child with a disability, no one wishes or desires to become a parent of a child with mental retardation or other developmental disabilities. It has been my observation that our society offers very little support in the way of educating and training parents. It is just something we are supposed to know. Parenting is demanding enough. When you add the extra challenge of working with a child who happens to have a developmental disability, the pressures, demands, and workload all but double.

At this point I hope that you have a better concept as to why I consider parenting a profession. My husband and I had no training or background in the world of the developmentally disabled. However, we now feel that we have earned associate degrees in Physical Therapy, Speech Therapy and Occupational Therapy, not to mention the health care specialties of Pediatric Cardiology, Neurology, Radiology, etc.

Experts agree that the majority of mental and physical growth occurs in children during one's "pre" school years. With this thought in mind, the combination of an early intervention infant stimulation program and preschool training have enhanced my daughter's opportunities to become a successful, productive member of society when she becomes an adult.

Unfortunately, there are thousands of infants and preschoolers in many states who are mentally retarded who do not and will not in the foreseeable future have opportunities like Victoria has had. Our Association last week conducted a phone survey of 20 state ARC chapters from the 29 states not fully serving children below four years old to ascertain those states' plans, as best as can be determined, in regards to infant intervention and preschool services for children with disabilities. The results of our survey indicate that 19 of the 20 states surveyed whose current special education mandate starts at age four or above are not planning to lower their mandate. Some of those states have tried but failed to lower their state special education law mandates and/or initiate early intervention services for infants with disabilities.

Clearly, parents in a significant proportion of our states, about one-half, have little or no hope for their child to receive preschool or infant services, yet we know how vital they are to achieve more independence. Since many of the states won't provide these desperately needed services themselves, we must look toward the Federal Government to provide the mandate. Our organization and others had to turn to the Congress in the early 1970s to mandate special education. The Congress met that challenge in 1975 by enacting P.L. 94-142. Now, we turn to you again for more leadership. Early intervention and preschool services must be mandated by the Congress if they are to become a reality in all states. The Senate has provided you with a bill that must not be ignored, must not be held up until the next Congress. We strongly urge you to consider this vital legislation immediately. Again, thousands of infants with mental retardation and other disabilities are dependent upon you to move this bill in the House.

We recognize there are some difficult issues to be considered. None of these problems are insurmountable if the Congress, the education community and the disability community have the will to solve them. We have an opportunity today and for the remainder of this Congress to lower the special education mandate and provide early intervention services to infants that may not be available again for decades. On behalf of the thousands of parents of children like my daughter, I urge you, I implore you to place the highest priority on the passage of this legislation. The Association for Retarded Citizens stands ready to lend any amount of assistance necessary to work out an acceptable bill. We urge you to bring together the various parties to solve any difficulties surrounding this legislation. We can and must bring about legislation in this Congress.

The ARC commends you for holding these hearings and again, the ARC and the Consortium for Citizens with Developmental Disabilities hope you will give the issues your prompt and full attention. The babies with disabilities are waiting.

Mr. WILLIAMS. Gary Timmons, National Education Association. Mr. Timmons.

STATEMENT OF GARY TIMMONS, NATIONAL EDUCATION ASSOCIATION, REPRESENTING THE NATIONAL EDUCATION ASSOCIATION

Mr. TIMMONS. Thank you very much, Mr. Chairman.

Good afternoon, my name is Gary Timmons, I am a lobbyist with the National Education Association, an organization of 1.8 million elementary and secondary public school teachers, education support personnel, higher education faculty and staff. NEA appreciates this opportunity to testify on S. 2294, the Education of the Handicapped Amendments of 1986.

Mr. Chairman, NEA has long supported policies at the national, State and local school district level that would ensure adequate free and appropriate education for all students, regardless of handicap and condition. We endorse the idea that programs for handicapped students should be developed through cooperative efforts of teachers, administrators and parents, and our members work to make that happen.

We also believe these programs should be provided in the least restrictive environment possible. In our view, a great stride in the achievement in these goals occurred in 1975, with the enactment of Public Law 94-142, the Education for All Handicapped Children Act.

Mr. Chairman, because you have made it clear that it is the Committee's intention that all prepared statements be printed in their entirety in the record of this hearing, with that understanding, I would like to just summarize some of the key points from my prepared statement.

First, NEA supports S. 2294, the bill to reauthorize expiring State discretionary programs introduced by Senator Weicker, and recently passed by the Senate. We urge this Committee to act on this reauthorization in the current Congress.

Second, I would like to emphasize that NEA strongly supports the new early childhood initiatives in S. 2294, that would help States serve handicapped students under the age of 5. Preschool incentive grant programs that already exists in current law, it seems to us, have served ample notice on the States of the Federal Government's interest in seeing that all preschool children will be served. It is now time to end the inequity whereby handicapped preschool children are served in some States, and not in others, by extending the Federal mandate to require the inclusion of children in the 3 through 5 age group.

We also applaud the establishment in S. 2294 of formula grants to States for the development and operation of early intervention services for handicapped infants from birth through age 2. Research clearly has shown the dramatic benefits of early intervention for handicapped infants.

My third point is an expression of deep concern that adequate funding be made available for these and all Federal programs of education for the handicapped.

Mr. Chairman, we are well aware of your own work in this area, as a member of the Budget Committee, in regard to securing adequate funding for education programs, as well as the work the other members of the Subcommittee present. Nonetheless, the funding record of the Federal Government since enactment of Public 94-142 has left something to be desired. When the 94-142 programs were first created, the stated intention of Congress was to increase substantially the Federal contribution to offset the costs of these programs.

The sponsors of this legislation clearly intended that the Federal share of these programs would be 40 percent. In our view, the Federal Government has a responsibility beyond that. In fact, we would like to see the Federal Government provide the full cost of federally mandated educational services at some point. Yet the reality is that the Federal share of costs associated with educating the handicapped has fallen from 12 percent to a mere 7 percent today.

As I mentioned earlier, the success of programs that serve preschool handicapped students, like all education programs, is dependent on a high level of cooperation among all concerned, including elected leaders at all levels, administrators, parents, teachers and students.

All persons concerned believe these programs to be as important as we do, yet under-funding undermines this cooperation and, sadly, that often means that some segment of the student population must suffer.

We urge the Committee to recommend funding levels that will provide the resources necessary to implement and operate quality programs. Furthermore, Congress must fund these programs in a way that will not detract from other equally important educational programs, or harm any other class of students.

My fourth and final point concerns the training and competence of persons who provide services to handicapped students. This new legislation presents Congress with the opportunity to provide greater guidance to the States regarding appropriate training, and certification requirements for these persons. S. 2294 contains a provision that services the handicapped infants in the 0 through age 2 category be provided by qualified personnel. Yet, no definition is offered in the bill, or the report which accompanies it.

NEA supports the recommendation of the Consortium of Citizens with Developmental Disabilities, of which we are a member, that was developed by the American Speech Language Hearing Association, which is also a member of CCDD, that qualified personnel be defined as, and I am quoting "Individuals who have met State established standards for obtaining a license to practice the profession in the State or in the absence of such standards, have met professionally recognized standards developed by a national certification board in the appropriate profession. In the absence of license, or registration, or national professional standards, the individual shall hold the highest State standard appropriate to the professional area in which he, or she is providing services."

It is common knowledge that the short supply of duly certified teachers in certain curriculum areas, and in certain areas of the country, has led many States to resort to issuing substandard, limited, or emergency teaching credentials to otherwise unqualified persons, in order to have the personnel necessary to operate the programs. In an effort to document this, NEA recently commissioned a survey of some 110 of the Nation's largest school districts. This survey reveals that critical teacher shortages are expected in a number of areas, including special education, when school begins this coming September. The average large school district will experience a shortage of as many as 25 qualified special education teachers at the high school level. Some 38 percent of the districts surveyed reported that they would be likely to respond to teacher shortages by assigning teachers outside of their field of preparation.

Due to a growing shortage of trained personnel, too often classes are being covered by unqualified persons. We are well aware, and can sympathize with the dilemma faced by local school officials in locating scarce qualified teachers, in order to comply with the law and operate mandated programs. But the use of unqualified and under-qualified personnel in our schools is absolutely unacceptable. Local school districts must stop assigning unqualified personnel to classrooms. States must immediately end the practice of issuing emergency certifications for this personnel.

Public Law 94-142 currently gives the States a free hand in issuing irregular certifications to fill vacancies in shortage areas, yet such so-called solutions to staffing shortages really create worse problems in the long run when Federal programs mandate services to handicapped students, and because of teacher shortages, unqualified personnel are too often assigned to provide those services.

We urge the Committee to consider providing better direction to State and local officials who must cope with this dilemma.

In conclusion, Mr. Chairman, and members of the Committee, NEA seeks prompt passage of S. 2294. We urge the Committee to recommend funding levels which will not lessen the Federal commitment to other educational programs, nor force difficult choices at the local school district level. We call for your support of needed certification requirements for those who staff these programs, and we ask your help in assuring that these programs are adequately funded in years to come for the benefits of the students they serve, and for the contributions these students can make to our society.

Again, I appreciate the opportunity to be here today, and I would be happy to answer questions.

[The prepared statement of Gary Timmons follows:]

LEGISLATIVE INFORMATION

TESTIMONY OF THE
NATIONAL EDUCATION ASSOCIATION
ON THE
EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

PRESENTED BY
GARY TIMMONS
LEGISLATIVE SPECIALIST

NATIONAL EDUCATION ASSOCIATION

JULY 22, 1986

MARY HATWOOD FUTRELL, President • KEITH GEIGER, Vice-President • ROXANNE E. BRADSHAW, Secretary-Treasurer
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Mr. Chairman and Members of the Committee:

My name is Gary Timmons. I am a legislative specialist with the National Education Association, an organization of 1.8 million members, including elementary and secondary public school teachers, education support personnel, and higher education faculty and staff. NEA appreciates this opportunity to testify on an issue of great importance, both to the handicapped students of this country, and to our nation as a whole.

The National Education Association views the education of the handicapped as a moral, social, and economic necessity. There is no question that great strides have been made in recent years toward providing appropriate educational opportunities to our country's handicapped students and that these efforts have resulted in far-reaching benefits to our nation. Since its enactment in 1975, the programs established by the Education for All Handicapped Children Act, P.L. 94-142, have helped ensure that that all students, regardless of handicapping condition, have an opportunity to grow to their fullest potential and acquire the knowledge and skills necessary to become contributing members of our society.

NEA has long supported policies at the national, state, and local school district level which would ensure an adequate, free, and appropriate education for all students, regardless of handicapping condition. We support the idea that programs to serve handicapped students should be developed through cooperative efforts of teachers, administrators, and parents. And we believe these that programs should be provided in the least restrictive environment possible.

NEA supports S. 2294, the bill to reauthorize expiring state discretionary programs introduced by Senator Weicker and recently passed by the Senate, and we urge this Committee to reauthorize the expiring programs in the current session of Congress. NEA also supports the new early childhood initiatives in S. 2294 that would help states serve handicapped students under the age of five. The already existing preschool incentive grant program has served ample notice to the states of the federal government's interest in seeing that all preschool children are served. Of the 57 states and territories, 47 already provide services to some or all of their handicapped students age five and younger. It is now time to establish adequate, appropriate handicapped education programs for preschool students aged three to five in every state in the nation.

We applaud the establishment in S. 2294 of formula grants to states for the development and operation of early intervention services for handicapped infants from birth through age two. Research clearly shows the dramatic benefits of early intervention for handicapped infants.

Significant Resources Are Necessary

There is no question that providing the type of quality programs that would be mandated under S. 2294 will require significant resources. The qualified staff, proper equipment, specialized materials, and other elements necessary to establish and maintain effective programs for the handicapped do not come cheaply. But the benefits of these programs, both to individuals and to our country as a whole, far outweigh the costs. Indeed, as a nation we simply cannot afford not to provide these essential services.

Yet rather than being a full partner in this quest for greater educational opportunity, the federal government is providing neither the leadership nor the resources necessary to the task. As the Members of this Committee are well aware, when the programs provided under P.L. 94-142 were first mandated, the intention of Congress was to increase substantially the federal contribution to offset the costs of these programs. The sponsors of this legislation clearly intended that the federal share of these programs would be 40 percent. In our view, the federal government has a responsibility beyond that -- to provide the full cost of federally mandated educational services. Yet the reality is that the federal share of the costs associated with educating the handicapped has fallen from 12 percent to a mere seven percent today.

Educational experts, public officials, and community leaders agree that handicapped education programs have immense value. The success of programs to serve preschool handicapped students -- like all education programs -- is dependent on a high level of cooperation among all concerned, including elected leaders at all levels, administrators, teachers, therapists, aides, parents, and students. Underfunding these programs undermines that cooperation, and, sadly, often means that some segment of the student population must suffer.

We urge this committee to recommend funding levels that will provide the resources necessary to implement and operate quality programs. Furthermore, we urge Congress to fund these programs in a way that will not detract from any other educational programs or harm any other class of students.

Certification Requirements Must Be Tightened

In addition to adequate funding, NEA is deeply concerned about the training and competence of individuals delivering these programs. We strongly urge this committee to take advantage of the opportunity this legislation presents to provide greater guidance to the states regarding appropriate training and certification requirements.

S. 2294 contains a requirement that services to handicapped infants in the zero through two age category be provided by "qualified personnel," and yet no definition is offered in the bill or in the Committee report which accompanies it. NEA supports the recommendation of the Consortium for Citizens with Developmental Disabilities (CCDD), of which we are a member, and by the American Speech-Language-Hearing Association, that "qualified personnel" be defined as:

> "individuals who have met state established standards for obtaining a license to practice the profession in the state or in the absence of such standards, have met professionally recognized standards developed by a national certification board in the appropriate profession. In the absence of licensure, registration or national professional standards, the individual shall hold the highest state standard appropriate to the professional area in which he/she is providing services."

The short supply of duly certified teachers in certain curriculum areas and in certain areas of the country has led many states to issue substandard, limited, or emergency teaching credentials to otherwise unqualified persons in order to have sufficient personnel to operate programs. A recent survey of some 110 of the nation's largest school districts commissioned by NEA reveals that critical teacher shortages are expected in a number of areas when school begins this September. For example, the average large school district will experience a shortage of as many as 25 qualified special education teachers at the high school level. Some 38 percent of the districts surveyed reported they would be likely to respond to teacher shortages by assigning teachers outside of their field of preparation.

Due to a growing shortage of trained personnel, too often classes are being covered by unqualified persons. We are well aware of the problems faced by local schools in locating scarce qualified teachers, but the use of unqualified or underqualified personnel in our schools is absolutely unacceptable. Local school districts must end the practice of assigning unqualified personnel to classrooms immediately, and states must end the practice of issuing emergency certifications.

P.L. 94-142 currently gives states a free hand in issuing irregular certifications to fill deficiencies, and yet under such circumstances, all concerned -- students, parents, schools, and our nation as a whole -- are ill served. We urge this Committee to provide better direction to state and local officials who must cope with this dilemma.

Conclusion

NEA seeks prompt passage of S. 2294. We urge this committee to recommend funding levels for these programs which will not lessen the federal commitment to other educational programs, nor force difficult choices at the local school district level. We call for your support of needed certification requirements for those who staff these programs. And we ask your help in assuring that these programs are adequately funded in years to come for the benefit of the students they serve and for the contributions these students can make to our society.

Thank you.

Mr. WILLIAMS. Thank you.

Alicia Smith, who is the Staff Director of the National Governors Association Committee on Human Resources, and is here representing the National Governors Association.

STATEMENT OF ALICIA SMITH, STAFF DIRECTOR, COMMITTEE ON HUMAN RESOURCES, NATIONAL GOVERNORS ASSOCIATION, REPRESENTING THE NATIONAL GOVERNORS ASSOCIATION

Ms. SMITH. Thank you, Mr. Chairman.

On behalf of the Governors, I would like to thank you for taking the time to hold this series of hearings, and to give careful consideration to some of the important issues involved in this legislation.

Knowing that my full statement is a part of the record, and since I am last, and since it is already after noon, I will be brief and try not to repeat too many things that you have already heard, but to make a few key points that I think the Governors would like you to consider.

First of all, we would like to recognize that it is as a result of the work of this Committee and of Federal legislation that so many children in the States have been able to take advantage of educational opportunities, that States have been given both the impetus, and in some cases, the wherewithal to implement a series of programs to serve this particular population.

We welcome continued Federal commitment to serving this population. We would like you also to know that Governors have come to believe very strongly in the concept of prevention and early intervention. In fact, if you do a quick check of the state-of-the-State addresses around the country this past year, you will find that there are only four governors who didn't mention the word "prevention" and/or "early intervention" in their State-of-the-State addresses. In almost every case, that mention was in relationship to children and their needs.

We believe that the task that faces you is the same task that faces us, the dilemma is how to provide for this important new initiative, without jeopardizing the funding and the provision of services to other population groups that also have legitimate claims on government assistance and services.

As you have been told already this morning, CBO estimates on the cost of this bill by 1990 to the States range between $530 million and $2.7 billion. The Federal Government historically has contributed less than 10 percent of the funding for public education in the States. I guess what all this comes together to suggest, from our perspective, is that you be sensitive to the fiscal condition of the States, as you consider this piece of legislation.

The recent study that was published by the National Association of State Budget Officers suggests that in fiscal year 1986, 17 States around the country had to take significant reductions in their budgets, in order to meet their State mandated balanced budget requirements, their constitutional requirements. Arkansas went back to the table four times to reduce their budget in 1986.

The fiscal outlook in fiscal year 1987 is not significantly better, already six States have cut their 1987 budgets, Texas is looking at a projected State budget deficit of some $2.3 billion; Montana's legislature has just cut $150 million out of its budget, in order to achieve constitutionally mandated balanced budget.

So, if it is Congress's intent to provide an entitlement program to this population, then Congress must help us with sufficient funding.

Our experience with 94-142 has, frankly, left us a bit disappointed with the commitment to funding. The initial authorization of the EHA envisioned a Federal contribution of 40 percent costs. But in 1986, the Federal Government's contribution was roughly 9 percent of the average cost per pupil; and next year's projection is that that would be reduced to 7 percent.

In short, what that suggests to us is that a new mandate must be come with the assurance of an adequate funding level to forge a real partnership.

How can you do that? One of the ways in which this Committee could do that would be to provide in your authorization bill a minimum Federal funding floor that would assure that the program would only be mandated, if sufficient Federal funds were provided to the States to carry out the mandate.

I think someone said earlier here this morning that you can mandate a lot of things, but if the resources aren't there, what you get is a less than desirable array of programs, potentially more harmful than good.

It is already the case that 19 States around the country have implemented a program for the 3 to 5 year old population, and I think this is a positive result of your current legislation, which gives States, at their own option, the incentives to develop programs and implement programs for the 3 to 5 year old population, and allows them to take into account, as they develop that and as they mandate it at the State level, what their resources are, and what their own State initiated priorities are.

Virtually every State at this point has applied for, or has the beginnings of the planning grants to begin to take a look at plans for the implementation of a mandatory 3 to 5 year old program. In fact, in Section 623 of the legislation which authorized these planning grants, Congress recognized that it was important to set realistic timeframes and give the States sufficient flexibility to evolve these programs in the context of all the other things that they are responsible for doing for their citizens, by giving some seven-year lead time. We would suggest that you take a look at that timetable, as you consider the implementation of the mandated 3 to 5 year old program.

With regards to the 0 to 2 program, I guess our primary concern here is sort of a threshold question, and that is is it appropriate to include the 0 to 2 population in a bill which is primarily directed at educational services? Is it appropriate to provide the same array of services to a 0 to 2 population that you now apply to the preschool and school-aged populations?

I don't know what the answer to that question is. I would suggest to you that research doesn't give us very good guidance at this point. What it does suggest, and what has been said here this morning, and we know this in our guts, is that the earlier you begin to provide services to this population of kids, the better.

But what services should they be, how should we define the population of children—I think an expert in the field suggested this morning that there are a variety of definitions of how you define the population in the infant to 2-year-old category, and that along with the definition that a State arrives at comes differing arrays of services, depending on the definition.

So, we would suggest that this substantial and significant numbers of unanswered questions about the infant to 2 population would suggest that it might be appropriate to separate this particular category of kids from the bill before you, and to take that under separate consideration, so that we might work together to bring some satisfactory conclusions to the questions that you have posed, and the additional questions that we have raised.

I would say this that, in regard to the suggestion made earlier that it would be, perhaps, appropriate to leave to the States the definition of the population 0 to 2. I think the States recognize that it is not fair, on the one hand to say to you, as Congress, leave us alone to define our own population, but when we do, we want you to fund it. So, I think that is a question where we need to come together on who that population is, and what array of services would be provided to them.

In conclusion, Mr. Chairman, I would like to offer the services of the National Governors Association, particularly, should you decide to take a separate look at the 0 to 2 population, in assisting you and your staff to take a look at the array of services currently available. There are some seven States that currently provide services to the population 0 to 2; to help you take a look at the ability of States to fund those services, what those services cost, what the array looks like. We would be more than happy to assist you in gathering that kind of information, and in any other way we might, as you continue to wrestle with this piece of legislation.

Thank you.

[The prepared statement of Alicia Smith follows:]

National Governors' Association

Lamar Alexander
Governor of Tennessee
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT OF

ALICIA SMITH
STAFF DIRECTOR
COMMITTEE ON HUMAN RESOURCES
NATIONAL GOVERNORS' ASSOCIATION

before the

SUBCOMMITTEE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

on

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986
(S.2294)

July 23, 1986

Mr. Chairman, members of the subcommittee, I am pleased to be here today representing the National Governors' Association (NGA).

On behalf of the nation's Governors, I would like to express our appreciation to you for your efforts to address the needs of handicapped children. With your committee's assistance, we believe that the federal government has played a key role in helping states provide special educational services for economically disadvantaged and handicapped children. Without the Education for the Handicapped Act, states could not have begun to give adequate attention to children with special learning problems.

The Governors believe that there is a shared federal-state responsibility to target educational opportunities on children whose poverty or handicapping condition impedes their educational progress. We welcome a continued federal commitment to provide these equal educational opportunities for handicapped children. Governors have also taken active roles to increase state efforts to provide an innovative array of educational and social services-related prevention programs for disadvantaged and handicapped children.

We believe that any revisions of current legislation need to provide a constructive federal role to help states in provide educational services to handicapped children, while continuing to allow states and localities sufficient flexibility to implement programs that responded to the needs of their people. Starting from this belief, I would like to discuss some of the issues presently before you with regard to the (Education of the Handicapped Amendments of 1986 (S.2294).)

Proposed New Mandate Extending Services to Handicapped Children 3-5 Years of Age

States recognize the importance of investing resources in early intervention programs for handicapped children. However, Mr. Chairman, as you are aware, both state and federal policymakers face a similar dilemma, that is, how to find ways to finance a new initiative without jeopardizing the provision of services to the other population groups that require similar governmental assistance.

The Congressional Budget Office (CBO) has estimated that in 1990, if all states are required to provide educational services to handicapped children from ages three to five potential costs to state and local governments are between $500 million and $2.7 billion. While estimated per pupil cost for serving three-to-five year-olds may vary among the states, reflecting differences in particular state-local revenue systems, reality is that the costs of providing assistance to handicapped children ultimately will be borne, for the most part, by the states and localities.

States and localities have assumed primary responsibility for education in the states. Historically, the federal government has provided less than 10 percent of the funding for public education. We believe that any extension of a federal mandate for education, particularly one without guaranteed federal funding, must be sensitive to the fiscal condition of the states.

Based on most recent survey conducted by the National Association of State Budget Officers (NASBO), at least 17 states had reduced their Fiscal 1986 budget in order to end the year with a balanced budget. The state of Arkansas enacted four budget cuts to avoid a deficit. And the fiscal outlook for 1987 is not very encouraging. Only two weeks into the new fiscal year, at least six states have already cut their 1987 budgets. The state of Texas is facing at least $2.3 billion budget deficit for its current two-year budget period and its deficit is likely to go up. The Montana legislature just held a special session to avert a pending fiscal 1987 deficit by reducing its budget by $150 million.

We need your guidance and assistance, Mr. Chairman and members of the subcommittee. If it is the intent of this Congress to provide an entitlement program for the education of handicapped children, Congress must provide sufficient funding to help states and localities meet the costs. But the experience we have had with the previous authorization of the Handicapped

Education Act (P.L. 94-142) left us with great disappointment. Based on the promise of a true state-federal partnership, the initial authorization of the Handicapped Education Act envisioned a federal contribution of 40 percent of the cost. Yet in 1986, the federal government's contribution to the cost of special education was only 9 percent of the average per pupil expenditure. The administration in 1987 wants to reduce that commitment even further to 7 percent.

If Congress feels so strongly about providing educational services to handicapped children, a new mandate to the states must come with assurance of adequate funding to forge a real federal and state partnership. This assurance could be achieved either by increasing the federal share of the cost to the level originally envisioned by Congress, or by using the authorization bill to provide a minimum funding level adequate to provide states a guarantee of adequate federal commitment.

We feel strongly that a federal mandate, particularly one without full federal funding, must take into account program priorities and activities initiated by the states. Currently about 19 states have a state-initiated mandate to provide special educational services to handicapped children aged three through five. We believe that these state efforts are positive results of the implementation of current legislation that allows states, acting on their own initiative, to develop a state mandate to serve handicapped children, after careful assessment of state resources and program priorities. Under current law, virtually every state has applied for a planning grant to assess needs and establish procedures for the development of an early childhood educational program. This is a positive indication that states are seriously looking at statewide provision of educational services to handicapped children for ages three to five, but within a realistic timeframe and with flexibility to determine priorities at the state level.

We believe that current legislative authority for early childhood education planning, development, and implementation grants to states provides a more realistic and rational timetable for the effective date of a federal mandate. Under Section 623 of current law, each state may receive grants for two-year planning, three-year development, and two-year implementation periods to phase in early childhood education programs over seven years.

Mr. Chairman, planning, development, and implementation grants were instituted by Congress in 1983, because Congress recognized the need to provide a workable timetable for states to assess needs, develop plans and procedures, develop state interagency working models, forge state-local partnerships, and to provide a revenue base to meet the additional demand for services without creating competition for governmental assistance with other needy populations in the states. We believe the timetable provided in the current law should be given serious consideration by your committee as you deliberate about setting a reasonable effective date for a federal mandate.

Proposed Optional Program for Children from Birth to Two Years of Age

We believe that early intervention services to handicapped infants are valuable and that the provisions in the bill to establish state programs to provide education and related services to handicapped infants at state option are well-intentioned. In fact, seven states already provide an array of intervention services to this population. However, we have some concerns about attaching a program of services to this population to this particular piece of legislation with its emphasis on educational services. Our threshold question is, is it appropriate to target the same or similar kind of educational experiences targeted to the school- and preschool-aged population to infants? Mr. Chairman, we believe the answer to that fundamental question is still unclear.

Since we believe the research is still too tenuous to arrive at many conclusions beyond the notion that the earlier we provide intervention strategies to any population "at-risk the better,"", we don't have answers to the good questions posed by this committee. However, we have a few additional questions that trouble us:

- Is there enough information available to know what "substantially developmentally delayed" means in the context of this very young age group?
- What is the potential negative effect of labeling an infant "substantially developmentally delayed" from the onset of its life?
- Many of the services described in the "to include but not be limited to" list seem inappropriate for the infant to age two population, i.e. occupational therapy. Do we not run the risk of diluting the strength of the educational programs for the three-to twenty-one-year-old population by trying to include infants to age two in an array of services primarily educational in nature?
- What is the appropriate role of the parents for a population as young as infancy through age two? Who assumes liability in the case of legal disputes between the state and the parents?

This committee well recognizes the dirth of available information about the appropriate services and their availability; that is why you have asked for a GAO study. We would respectfully suggest which such a study, as well as a synthesis of research findings from the states which have enacted programs for this age population be carefully considered by the committee before designing even an optional program of services to these children.

Perhaps the best way to address the issues you have raised and we have added to is to separate the infant program from the three-to five-year-old program at this time. Addressing the infant program in separate legislation in the near future will give the Congress and the states time to look both at the current services being provided to handicapped infants and the optimum array of services that might be provided. Mr. Chairman, the National Governors' Association offers its assistance to you in collecting information on services presently provided, costs of those services, and the ability of states to fund those services given their existing priorities and resources.

The Governors appreciate the care with which this committee has approached this complex issues. We look forward to continued cooperation with you as we work together to resolve the issues before us.

Thank you.

Mr. Williams. Thank you, Ms. Smith.

Mr. Bartlett.

Mr. Bartlett. Mr. Chairman, first of all, let me see if each, or if any of you have estimates as to what you believe the accurate estimate of the number of children that are currently unserved, but would be served by this mandate of 3 to 5. The Department of Education has recently concluded that in their opinion the States that have mandates and the ones that are serving these children without a mandate, that approximately 91 percent of all handicapped students, 3 to 5 in the country are already being served, leaving only about 27,000 children throughout the country to be served, if this mandate were to go into effect. Others have estimated, as you know, that the total size of the population could be as much as 200,000 to 300,000 more children.

If you were in our shoes, how would you get a handle on the number of 3 to 5 population that is presently unserved, that would be mandated to be served?

Ms. Smith. Well, how you get a handle on it is—that's a tough question, that's one of those places where an association like the Governors may be able to be helpful in surveying the States.

I can tell you this, Mr. Bartlett, from the figures that I have before me, in the 19 States that have already implemented mandatory programs for the 3 to 5 population, there are 136,000 roughly, children being served out of a total population in that age group of almost 5 million, or about 3 percent of the children age 3 to 5 are being served.

Now, that is not the same thing—that is the percent of children being served of the total eligible population; that is the percent of children being served of the 3 to 5 populations in those States.

If 136,000 children are being served in 19 States, it doesn't make sense to me that there are only 27,000 unserved children in the rest of the country.

Mr. Bartlett. Ms. Smith, is it your observation, or has the Governors Association reached a conclusion as to whether States without mandates are serving their children age 3 to 5 anyway?

Ms. Smith. I would think that there are some cases where, at least in some not very well structured, or coordinated way, there are some services being provided to children 3 to 5. But our figures are only from the formal programs where States have actually mandated those services.

Ms. Bartlett. I think we could use some additional information from the Governors association, and I would seek to work with the association to try to reconcile the two different conclusions, because I think it does make a substantial difference as to cost.

The second question is, of those States that currently don't have 3 to 5 mandate, are those States, in your opinion, moving toward adopting a 3 to 5 mandate, or will they continue not to have a mandate, if Congress does nothing?

Ms. Smith. I think the fact that over the course of just a relatively few years, 19 States in some of the worst economic times that States have seen in a long time, have moved toward implementation of that mandate suggests that States are serious in the planning and development of programs for the 3 to 5 population.

As I said at the beginning of my statement, there is scarcely a Governor left in the country who doesn't implicitly understand the value of prevention and early intervention services. I think they are all pushing that very strongly, not only with rhetoric, but with State dollars.

Mr. **Bartlett**. We are going to have to go vote—let me try to ask each one of you to respond to a question—and I just want to make certain that I understand how you then come down on the bill.

As I understand, the Association of School Administrators would oppose the legislation; the Association of Retarded Citizens would support the legislation; the Governors Association and the NEA, would you urge us to pass this legislation, or not pass the legislation this year?

Ms. **Smith**. Mr. Bartlett, what we would urge is that if you are going to create this mandate for the States, it has got to be followed by some significant assistance in the funding of the program, otherwise we would not be able to support——

Mr. **Bartlett**. I understand, but this bill doesn't have that, I believe it has an extra $100 million in it.

Ms. **Smith**. We would not be able to support a mandate to the States at this time, without some guarantee of sufficient financial assistance to carry out the mandate.

Mr. **Bartlett**. And the NEA?

Mr. **Timmons**. We support the legislation, Mr. Bartlett. We have similar concerns about how it is going to be paid for.

Mr. **Bartlett**. Thank you.

Thank you, Mr. Chairman.

Mr. **Williams**. Do my colleagues have any——

Mr. **Hayes**. We heard the bell, so I don't have any questions, just a comment. I think the last question my colleague, Mr. Bartlett, raised sort of cleared up—I wanted to know each of your respective positions.

I understand you very clearly, Mr. Sheldon, you said that you could not support this legislation, without accompanying funding, is that right?

Mr. **Sheldon**. That's right.

Mr. **Hayes**. And you essentially say the same thing?

Ms. **Smith**. Yes, sir.

Mr. **Hayes**. You say, Mr. Timmons, that you would support the program, you have no problem if the money is raised. You raised the question of the qualified teachers, which is tied in with the question of money. I have sat on several different subcommittees, and the problem of getting teachers, even into educational training for teaching purposes of that profession, is declining because of salary levels. I know this is the kind of thing that we have got to address ourself to, and I understand your position.

You mentioned something about the possibility of documentation of some of the teachers to some of the kids who were unqualified. I would like to have the privilege of viewing some of that documentation, if possible.

Mr. **Timmons**. Yes, Mr. Hayes, there is a collection of the special certification practices in the various States that is compiled each year by the National Organization of Directors for Certification, I would be happy to submit that information to the subcommittee.

Mr. **Hayes**. Thank you.

Ms. Reedstrom was very clear, she wants us to act in this Congress, is that right?

Ms. **Reedstrom**. That's right.

Mr. **Hayes**. Thank you.

Mr. **Williams**. Each of you have indicated, as have most previous witnesses on issues similar to this, that if the Federal mandate is going to come down, the appropriate money should follow it. That seems to be the popular, overwhelmingly opinion in America, at the same time that people are asking the Federal Government to reduce its spending.

So you all are aware of the dichotomy that faces the Congress, in trying to meet both of those popular mandates. But let me ask a question with just the little bit of time remaining, before we have to adjourn this hearing, a question that would be better asked if we had a half hour remaining, and that is with regard to the philosophy of the issue.

If the Federal Government looks at the States and finds that they don't provide appropriate housing for poor people, why shouldn't the Federal Government mandate that they do so?

If the Federal Government looks out at the States that have the authority to provide appropriate education free to handicapped and disabled persons, and that they aren't doing it for young people, why shouldn't the Federal Government mandate that those local citizens do it and pay for it, after all it is a requirement?

If the Federal Government finds that cities and localities, and the States don't have appropriate transportation for their people, and it says that it should, and it mandates it, why shouldn't the Federal Government have to pay for that?

Why shouldn't the States, the cities, the counties pay their own way, instead of asking—New Yorkers asking Montanans to pay for Midtown Manhattan, and Montanans asking the New Yorkers to pay for our buses in Missoula, MT—what is it about this system that should require the Federal Government to pay for everything that the States and localities should have done on their own?

I don't want to sound a great deal like Ronald Reagan, but he has asked that question a lot, so let's see what your answer is.

Does the Governors association know why—why should we continue to raise the taxes, while your Governors cut the ribbons, usually on a Wednesday, when we can't get out there to join in the ceremony, why is that?

Ms. **Smith**. Well, I think there are a lot of Governors asking themselves the same question, Mr. Chairman.

I suppose without getting too deeply into a philosophical discussion with you, that what you are asking are some basic questions of federalism that we have been wrestling with a lot, talking about a lot over these last several years. I suppose the question, and certainly the question posed by the Administration, and a number of their suggestions is what is it, from a national perspective, that we agree, as a Nation about our society we all ought to do, and then how do we fund those things?

For all of those things which are not specifically put in the hands of the Federal Government, either constitutionally, or through popular vote, or the will of the people, those issues which are reserved to the States, we would suggest that the States have the right to make their own determinations as to whether it is important enough in their scheme of things for the States to allocate and to ask their citizens to allocate a certain portion of their tax dollars to fund.

So, I think you are asking an important question, one that certainly wiser heads than I have attempted to struggle with and come to no very good conclusions, as yet.

Mr. WILLIAMS. Thank you.

Mr. Sheldon, let me ask you then to answer that question, if you will, from the perspective of the school administrators, who really are responsible for providing, it seems to me, this type of service. Why shouldn't the local taxpayers pay for it, instead of the Federal Government?

Mr. SHELDON. If the local taxpayers were given the latitude and the sole responsibility for determining what should be provided by way of education for their children, then I think that it would be very appropriate for the Federal Government to back out.

The local initiative, local control issue is certainly fundamental to this and central to this issue. But one of the concerns I have—if I may just add very briefly this comment—when there is a mandate for a program emanating from the Federal Government which impacts on local school districts, oftentimes the consequence, the full range of consequences of that act, or that legislation, are not clearly understood at the time that it is implemented—designed and implemented.

For example, I would see a mandate now with this legislation, following this legislation to have the potential for impacting on the way we are addressing the Title I, or Chapter I students, the disadvantaged youngsters. I see a further disparity developing, further lack of equity developing between the haves and have-nots if we are to do this.

The more mandates that are applied to a local school district without sufficient funding coming from sources other than local, the greater the negative impact on the provision of services across the board.

Mr. WILLIAMS. Mr. Sheldon, let me interrupt you for just a moment to say to my colleages that I know that bells have rung, and I want to pursue this a few minutes. We won't consider it rude, of course, if you feel that you have to leave to make this important vote—you don't want to miss anymore of them——

Please.

Mr. SHELDON. For example, if the 94-142 were expanded to the 3 to 5 mandate, with the level of funding that is currently a part of the 94-142 also being extended to that program, that still leaves a local district with an obligation that ranges from, perhaps, 40 percent to 60 percent, or more local effort, local initiative.

If that is true, then that is going to siphon off dollars that are being spent to address the Chapter I students, and the problems in that area. It will siphon off the funds that are being utilized to address the requests of the parents of gifted children, it would siphon off dollars for a whole host of services that are now being provided students.

I recall some data about New York City, 35 percent or more of the students in that city drop out. New York City, I believe, if my memory serves correctly, is going to utilize about $30 million of its own resources to address that particular problem. If that city were to be required to serve 3 to 5 year old students, without some very substantial funding following, their dropout problem is going to continue, perhaps with some break, some modification, some easing, but it would, nonetheless, be a serious problem.

So, there is a finite supply of dollars available to local school districts, and that supply of dollars has been taxed at an ever increasing rate over the past few years.

Yes, we recognize that there are a dozen States, or more in fiscal year 1987 that are at zero, or deficit balances. There are a lot of school districts, too, that are in similar dire circumstances.

It is a rather long response, Mr. Williams, but it is a complex question that you pose, a very fundamental one.

Mr. **WILLIAMS**. Yes, and it is particularly fundamental, or I guess it is particularly realistic, given the insistence of the public, through the Federal Government that localities and States meet certain standards of service. Yet, doing that at a time when there is this very difficult deficit, which now, because of a lack of economic growth, does not appear to be getting smaller, as we had anticipated when we made the cuts earlier this year in the budget committee, but rather are getting larger, because there is no growth in the economy.

So, you know, it is a realistic question.

Mr. **SHELDON**. It is a matter of priorities, I guess, for us, Mr. Chairman. That, I feel, in the main should be the consequence of local initiative, local determination.

Mr. **WILLIAMS**. But you see, the question is, when you say that we should leave to the States and localities to determine, for example, who should be served, then they are willing to pay for it. But what do you do when, after 50 years, or 100 years, or 200 years, depending on how you rate the time, if free, appropriate education is still not being provided by those localities to disabled youngters?

How long should the American public wait for some States to get with it? That's the question. The American public uses the Federal Government to say to certain States "That's it, times is up, let's go".

Now, your point is should money have to follow that mandate, and all of you are saying, oh, yes, you shouldn't mandate, if you don't come with money. Maybe.

Mr. **SHELDON**. Or perhaps relax the standards someplace else. But I think we have reached a point now where the public has spoken, they have demonstrated a lack of—through the excellence reports—a lack of appreciation for the effort that the State has gone into public education, at least up until 1983. The problems there that were identified through those reports command resources to address.

I realize that dollars don't provide all of the answers, certainly there is the question of quality that one can address without extensive outlays of dollars. But when one looks to the need perhaps for additional classes to better provide students for the 21st century, or even for 1990, and that decade, when one looks to the need for smaller class sizes, more teachers; when one looks to the need for increased salaries to attract and retain qualified teachers in some of our very critical areas, then we have some very, very difficult decisions with which to deal. Math-science, of course, is one of the areas of serious concern in the country.

I don't have a pat answer for you, Mr. Chairman. I have similar concerns, I think, to those you expressed.

Mr. Williams. Thank you very much.

Mr. Timmons, I want to thank you and the NEA for raising the critical matter of having the personnel in place to provide the services which might be mandated, whether money follows or not, we need the personnel there to carry out the necessary services. You are correct, in some given disciplines, we have a crisis and a shortage of teachers. We have a crisis in appropriate salary for teachers, which leads to the former crisis. We appreciate NEA's good work in that area.

Ms. Reedstrom. Mr. Chairman, I want to make one point in regard to a viewpoint from a parent, and what I see happening in South Dakota, and I hope not in other States that have brought the mandate down below what the current Public Law 94-142 States.

We have been lucky, my husband and I, to have raised Vicki in Minnesota, Nebraska and South Dakota which has good special education services. But currently this year in South Dakota, we are seeing the legislature reviewing their school aid formula, and the only thing that they are looking at, the only thing that they are addressing is special education.

That really concerns me as a parent, right now in South Dakota, we service from birth or diagnosis on. But that makes me think they are looking on raising it to the minimum, rather than the maximum, and that very much concerns me.

Mr. Williams. I was very interested, Mrs. Reedstrom, in your comments about Victoria. I am the godfather of a youngster named Keough Duffy, K-e-o-u-g-h. Keough was born a Downs Syndrome baby, and had some of the resulting difficulties that Victoria has had. So, being her godfather, I have watched, tried to help some, but primarily watched closely as the parents went through much of the effort that you and your husband have gone through.

Having seen that up close, I am more convinced than ever that among the most heroic and loving efforts that are made in America, are made by the parents of children with these types of disabilities. So, I am particularly pleased that you are here, and that you shared with us your child's difficulties, and you and her efforts, apparently successful, to overcome those at this point.

Ms. Reedstrom. So far, so good.

Mr. Williams. Well, our thanks to each of you. You, too, have been very helpful and we will adjourn this hearing, and have a second hearing tomorrow.

Thank you all very much.

[Whereupon, at 12:55 p.m., the subcommittee adjourned, to reconvene on Thursday, July 24, 1986.]

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

THURSDAY, JULY 24, 1986

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to call, at 11 a.m., in room 2257, Rayburn House Office Building, Hon. Pat Williams (chairman of the subcommittee) presiding.

Members present: Representatives Williams, Hayes, Bartlett, and Goodling.

Staff present: S. Gray Garwood, staff director; Robert Silverstein, majority counsel; Colleen Thompson, clerk; and David Esquith, minority legislative associate.

Mr. **Williams**. Good morning. I call to order the second day of hearings from the Subcommittee on Select Education concerning S. 2294, the Education of the Handicapped Amendments of 1986.

I'll ask our first panel to take the witness—the table: Jacqueline Vaughn, Verna Hart, James Oglesby, Martha Ziegler.

We'll begin the testimony today with the President of the Chicago Federation of Teachers who is here representing the American Federation of Teachers, Jacqueline Vaughn. I know that our friend and colleague, Mr. Hayes, knows Ms. Vaughan and, I'm sure, would like to introduce her.

Mr. **Hayes**. Thank you, Mr. Chairman. I'll be brief. Ms. Vaughn—as you've said, I know her quite well. She's the President of the local 1, Chicago Federation of Teachers, as well as International Vice President of the American Federation of Teachers, one who is quite capable of giving this Committee some insight as to the views, her own views, as well as the views of her union, on this important subject matter of the handicapped and how we address ourselves to this question as contained in the proposal as such.

It gives me great pleasure, as well as a privilege, to present to the Committee, Ms. Jacqueline Vaughn.

TESTIMONY OF JACQUELINE VAUGHN, PRESIDENT, CHICAGO FEDERATION OF TEACHERS

Ms. **Vaughn**. Thank you, Mr. Hayes, Mr. Chairman. I am Jacqueline Vaughn, Vice President of the American Federation of Teachers, President of the Chicago Teachers Union and a former special education teacher.

I'm delighted to have this opportunity to address you on S. 2294 and share with you the concerns of the American Federation of Teachers and those members I represent about a proposed amendments which indeed will create some problems in our area. In particular, in terms of funding, if indeed this is not considered as we have stated in our testimony an entitlement so that the Federal Government assumes its fair share of funding such increased responsibilities that will be put onto the State and local governments.

The AFT, the Chicago Teachers Union and the Illinois Federation of Teachers have been on record as supporting legislation and Public Law 94-142 which enabled children with special needs to have special education opportunities.

In our own area in Chicago, in particular, we were pleased to know that we were successful in our lobbying efforts in getting that legislation passed and young people who live in our area took advantage of this opportunity; and we have a very successful program operating.

We were concerned, however, that the mandate was never fully funded to the extent mandated by the law, and that there were many problems that were generated as a result of public law 94-142 that have not been resolved because of the inadequate funding. These problems are related to I.E.P.'s; a shortage of appropriate personnel, services, resources; and the increased financial burden that has been placed on the State and the local education agencies.

One of the other problems that we are concerned about is the fact that, in many States, education form initiatives have begun. In Illinois, in particular, we were just successful in getting additional dollars allocated for education throughout the State and in Chicago, in particular.

That means that we were able to get during this last legislative session early childhood programs for ages 3 to 5 for the so-called normal children. We had problems in that we had inadequate funding available.

We have just finished our national convention where we dealt with this resolution and the pending legislation. While we support and adopt the concept, we are seriously concerned about these areas, about the fiscal conditions of the State and local government, and the fact that the amounts that the Governor had anticipated receiving were less than those that actually came to fruition.

In order to make the necessary allocations to our particular school district, 299, there had to be additional cutbacks in budget allocations after they had been adopted. In order to assure that in our particular district we would not be involved in a strike and another controversy, the Governor made adjustments which would let us have our school district open without the confrontation this time, but including additional revenue for early childhood programs, expanding those programs which already existed by some ninety additional schools.

We are concerned that, if we now mandate an extension of these services without providing a significant increase in Federal dollars to the State and to the local school agencies, we will have a serious problem in meeting those mandates.

We have included in our testimony the concerns that we have and also a copy of the resolution that was adopted at our last convention this past July. In that resolution we pointed out that we endorsed the concept, but we feel that our support for S. 2294 would be contingent upon the law being made a Federal entitlement whereby the Federal Government would undertake the responsibility for paying a fair share of the cost that would be involved in providing these services to all children.

We want all children to be provided a free public education, as was mandated by 94-142, and we're fully aware that some 19 States mandate it now. But what about those States that do not have the mandate? What about the cost? How would we determine how many students would be required or be eligible? What kind of child find systems would be enacted, and what kind of legislation would be put forth in the States in order to meet these mandates?

I would be happy to answer any questions that you might have relative to the testimony either in written form or the remarks that I have made in my opening statement.

[The prepared statement of Jacqueline Vaughn follows:]

TESTIMONY OF JACQUELINE VAUGHN
REPRESENTING THE AMERICAN FEDERATION OF TEACHERS
BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION
U.S. HOUSE OF REPRESENTATIVES
ON S.2294, THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

July 24, 1986

Mr. Chairman and Members of the Subcommittee:

I am Jacqueline Vaughn, President of the Chicago Teachers Union and Vice President of the American Federation of Teachers. Thank you for this opportunity to testify on S.2294, the Education of the Handicapped Amendments of 1986. The AFT commends you for conducting this hearing, for I am sure you will be buffeted by controversy. I will comment, today, principally on the implications of a proposal to mandate a free, appropriate, public education for three through five year old handicapped children.

The AFT has always supported full educational opportunity for all citizens. In fact, the AFT was created in my city early in this century in a struggle to improve educational opportunity. Like you, and members of your subcommittee, we believe educational opportunity is essential to maintain a democracy necessary for re-establishing our position in international economic competition, and in the long-run it costs much less than lack of opportunity. The AFT particularly supports educational opportunity for those with special needs. We fought against cuts in programs such as Chapter I and Education for the Handicapped. We continue to believe that the federal government has a responsibility to help those who most need help.

The AFT is also an advocate of early childhood services. In the mid 1970's we devoted considerable organizational resources to promoting the idea of early childcare in the public schools. Owing to the increasing proportion of single parent households and households in which both parents work, we believed there was widespread need for such services. Most importantly, we knew that services provided at an earlier age could produce much greater educational gains, particularly with children who have special needs. Greater educational gains means, additionally, that services provided at an earlier age are more cost effective.

The AFT supported the concept behind P.L. 94-142, the Education of the Handicapped Act. At the time this law was enacted many handicapped children were excluded from public schools. A significant percentage of school-age handicapped children were not receiving appropriate educational services, or not receiving any services at all. Just last year we saw the tenth anniversary of that law, which required that all school-age children be given a free, appropriate, public education in the least restrictive environment. Looking back over the last ten years, schools have come a long way in meeting the intent of that law. P.L. 94-142 has had a great impact on the educational opportunities available to handicapped children but problems still exist.

These have included, among others, difficulties with I.E.P.'s; shortages of appropriate personnel, services, and resources; and an increase in the financial burden on state and local education agencies. Another problem I would like to mention is the teacher's lack of standing in due-process procedures under P.L. 94-142. The law assumes that teachers have no interest beyond that as a representative of the agency providing education. This position completely ignores the teacher's role as a child advocate and puts us in the postion of being unable to make the professional contribution we are capable of making.

Recently we had reason to believe there would be some improvement in the law with respect to the teachers status as child advocate. The House version of the Handicapped Children's Protection Act contained a provision which would have barred any retaliation against a teacher for encouraging or cooperating with an effort to secure a handicapped child's rights. Unfortunately, that provision was lost in conference with the Senate. Perhaps some successive legislation dealing with education of the handicapped will resurrect that provision and provide teachers with protection so they can speak out on behalf of their handicappped students.

In spite of some problems with the law, the AFT has consistently worked for increased federal funding of P.L. 94-142. Indeed, inadequate federal funding is one 94-142's major problems. As far back as 1977, the AFT testified in a hearing and asked Congress to drop the scheduled phase-in and immediately move federal support to the promised level of forty percent of Average Per Pupil Expenditure. In our recent testimony before the House and Senate appropriations subcommittees we requested, as a funding priority, regaining the twelve percent federal share over a two year period.

Currently, schools are not required to provide educational services for three through five year old handicapped children if to do so is inconsistent with state law or practice. S. 2294, which has passed the Senate and is the focus of todays hearing, would mandate such services. Obviously, the AFT supports the concept embodied in S. 2294. We realize that handicapped children who are provided earlier services will have substantially better achievement in school, will require less special education in later years, and their education and other services will ultimately cost society far less. The problem arises primarily in the costs of special education for earlier age groups and how those costs will be borne.

No one knows how much S. 2294 will cost. No one knows the number of children who need educational services or the average cost of serving each child. Surely the costs will be considerable. We do know the federal government has not met its commitment and responsibilities for funding P.L. 94-142. The federal share was to have risen to forty percent of Average Per Pupil Expenditure. I am told that would be approximately five billion dollars for this year. Actually, although federal funding has increased by one-third since FY'80, in real dollars it has gone down nine percent. More importantly, the federal share peaked at twelve-and-a-half percent of A.P.P.E. in 1979 and thereafter declined to the present level of about nine percent.

Quite obviously federal support never matched the promised, forty percent level.

S. 2294, as passed by the Senate, has serious fiscal implications for state and local governments. I understand that, at this time last year, at least thirty-one states and territories did not require educational services for some portion of the three to five year old category. As you know, the Senate report on S- 2294 estimates that the cost to state and local governments could run to nearly three billion dollars per year. The AFT does not believe the federal government should mandate such costs for state and local governments given the wretched federal record in providing support that was promised when 94-142 was enacted. Loading new expense on state and local governments may seriously undercut the educational reform movement that is emerging in many states.

The present fiscal condition of state and local governments must be described as mixed. A large number of states had to significantly cut their budgets this year after they were adopted. Sluggishness in the economy and the threat of a downturn offer other ominous signs. In addition, the uncertainty of federal actions, for example, the impact of tax reform, and the loss federal funding for many programs put stress on states and local governments.

Under present federal law, specifically Section 504 of the Rehabilitation Act of 1973, handicapped children must be provided educational services if such services are provided to non-handicapped children of the same age. That is, its against federal law to discriminate against handicapped children when providing educational services. S. 2294, however, raises a different issue. S. 2294 would require state and local governments to provide educational services to three through five year old handicapped children when they are not offered to non-handicapped children. This seems to be a significant move beyond the present circumstance and a qauntum level of federal intervention in state and local educational policymaking.

While endorsing the concept of educational services for three through five year old handicapped children, AFT believes such a mandate carries a greater obligation for the federal government to bear a fair share of the costs. State and local governments already bear something on the order of ten times the financial burden for P.L. 94-142 than that borne by the federal government. Accordingly, the American Federation of Teachers offers support for S. 2294 contingent upon the law being made a federal entitlement, whereby the federal government would seriously undertake the responsibility to pay a fair share of the costs involved.

At a recent meeting the AFT Executive Council, representing teachers and other educators across the country adopted a resolution on S-2294. In my testimony, today, I expressed the sense of that resolution. The text of the resolution is attached to my written testimony for your information. In conclusion, I would like to thank you again for this opportunity to testify. I'll be happy to respond to any questions.

RESOLUTION ON S. 2294

Adopted by the
American Federation of Teachers Executive Council
July 8, 1986

WHEREAS, the American Federation of Teachers has always supported quality education and related services for all children, and

WHEREAS, the American Federation of Teachers has particularly supported full educational opportunity for children with special needs, such as those who are economically disadvantaged or physically or mentally handicapped, and

WHEREAS, the American Federation of Teachers has supported, and does now support, the general objectives of P.L. 94-142, the Education of the Handicapped Act, which calls for a free, appropriate, public education for all handicapped children, and

WHEREAS, this law has never been adequately funded by the federal government, and the resulting burden has been felt in other areas of education, and

WHEREAS, the federal government currently pays only nine percent of the "excess costs" of educating handicapped children, which is far less than its original commitment to pay 40 percent of "excess costs" by 1982, and

WHEREAS, the American Federation of Teachers has consistently worked to increase federal funding of P.L. 94-142, and

WHEREAS, the U.S. Senate recently passed the Education of the Handicapped Amendments of 1986, S-2294, which extends the federal mandate for a free, appropriate, public education to handicapped children three to five years of age and also creates a program of grants to states for early intervention services for handicapped children from birth through two years of age; therefore be it

RESOLVED, that the American Federation of Teachers endorses the intent of S-2294 to provide early childhood education and services to handicapped children. Services at an earlier age are often more effective in helping children with special needs. The American Federation of Teachers endorses lowering the age at which services are required on the condition that their right be made an "entitlement" under federal law whereby the federal government will assume its fair share of the costs for providing federally mandated services to children five years of age and younger, and be it further

RESOLVED, that the AFT communicate to the Congress our union's opposition to establishing a new federal mandate that must be fulfilled by adhering to the prescriptive and expensive program for educating handicapped children found in P.L. 94-142 without mandating the federal aid necessary to carry out the law.

Mr. **Williams**. Thank you very much. Before going to questions, we'll go down the first panel of witnesses and hear from each of you. Professor Verna Hart from the University of Pittsburgh is here representing the United Cerebral Palsy. We appreciate your being here, look forward to your testimony.

TESTIMONY OF VERNA HART, PROFESSOR, UNIVERSITY OF PITTSBURGH, REPRESENTING UNITED CEREBRAL PALSY

Ms. **Hart**. I'm Verna Hart, a professor of special education at the University of Pittsburgh, but today I'm also testifying on behalf of the United Cerebral Palsy Associations, Inc. U.C.P. is a private, nonprofit agency with over 220 affiliates in forty-five States, dedicated to meeting the needs of persons with cerebral palsy and similar disabilities.

I have degrees in Speech Correction, Deaf Education and a Doctorate in Multiple Handicaps. Currently, I'm training teachers to work with young handicapped children, birth to 2.

I must admit that I alone did not make the decision to pursue a career in special education. I had not planned on teaching following the birth of my children, but my second child was born handicapped, and the expense of maintaining that child not only put me back in the workforce but led me to take both full and part-time jobs.

To supplement the knowledge gained from raising my son can be added that learned while grandparenting two grandsons, one handicapped as a result of a doctor's goof and the other who became handicapped as a result of the birth of his younger brother.

In the interest of time I'll merely highlight only parts of my written testimony.

As a parent and as a professional, I am committed to early intervention for handicapped preschoolers and have been involved in a series of studies that show that early intervention is effective. On a personal basis, early intervention really paid off where my own son was taken from an institution for the retarded while still a preschooler, educated in special education classes at 3 and 4, and then mainstreamed with his neighborhood friends for the rest of his education, including college.

You can see why I believe in early education. Most parents don't choose to have a handicapped child. In most cases, they would choose not to. Most families are shocked when informed that their child has problems, and I was no exception.

I was also shocked when my second grandson was delivered prematurely by Caesarean Section. I, who had made many professional trips to the neonatal intensive care nursery had a hard time seeing our baby among the many machines and tubes used to help him breathe. My daughter-in-law was even more upset. She fainted. My son was stoic, worrying first about whether the baby would survive, and alternately about how he would pay the hospital bill.

The most devastating reaction was shown by my 17 month old grandson. He no longer was allowed out of his apartment, because the newborn baby needed to be in cold mist and have electricity available to prevent his suffocation. It took both parents to care for the infant, and the toddler was left to fend for himself.

Understandably, he stopped talking and began to show acting out behavior. When the baby died in his sleep twenty-two months later, he thought he was responsible. He still carries the guilt and the impact of those early experiences.

Intervention can be cost effective. The graduates of such programs have become contributing members of society with less special education required, greater income as adults. They stay in school longer. There's less contact with the police. They're more apt to go on for higher education, and they're more apt to become taxpayers.

It's also the mark of a civilized society that its less fortunate members are cared for and that all members of that society have rights as members.

I'd like to discuss the legislation as it affects the two groups of preschoolers, the 3 to 5 group and infants. Only twenty-five of our States are currently providing services to preschool children, and I happen to live in one of the States that has neither permissive nor mandatory legislation for early intervention.

I daily see the result of such lack of legislation. Many children are penalized because of where they reside. I personally know the impact of trying to find a program for my son when there was none available. I had to get up early, dress and feed 3 preschoolers and a newborn baby and be on the road in order to drive my son to the next community for an 8:30 class.

I had to prepare my children's lunches to eat in the car. I drove back to the end of the bus line and put my kindergartner on it for her afternoon class, and then drove back to pick up my son. My children spent hours in the car every day.

I thought times had improved, and this was a practice no longer necessary; but traveling around the country, I find similar circumstances. My grandson is a case in point.

We could find no appropriate placement for him. Through professional contacts, I was able to find him a class in Pittsburgh. That meant that my son and his wife had to sign over the responsibility of their son to me. My grandson came to live with me and stayed for a year and a half.

In time my son was able to find a job in a city that had a very high unemployment rate, and moved his family so that my grandson could again return home. This has been at a cost to my son and to his wife, both emotionally and financially.

Prior to the passage of 94-142, I saw many unjustices to school age children as I traveled across the country. I see those same injustices today in the preschool population. The proposed legislation can prevent such injustices. The 3 years proposed for implementation time is more than realistic, for all States have been involved with planning grants providing preschool services to handicapped children.

There is much to be lost, and too many will suffer if we delay. The term "developmentally delayed" referring to those to be served seems particularly relevant. The problems inherent in requiring Special education labels prior to serving children arise time and again in discussions with professional colleagues.

It's difficult to place accurate labels on children during their early years. My son had six different labels. My grandson has had four and is currently being processed for another label change. Unrealistic rules can interfere with services, and our preschoolers need immediate help, not delays.

Early education can be particularly effective when administered during the first 2 years of life. I can use my second grandson as a case in point. From the time he came home from the hospital, we kept a close eye on his development. We all agreed that the child was not progressing normally, but the doctor insisted that his behavior was not unusual and that he would outgrow it.

At 8 months of age the baby was not able to hold up his head, something normal children do within the first 4 months. A new pediatrician prescribed physical therapy. Private intervention sessions began that week, and within one month the child was not only holding up his head, he was sitting independently, something that normal babies do in that age.

Following his therapy, motorically he became a normal child, and sessions ceased. If he had not had such intervention, the child could have had motor problems for the rest of his life. This is why I'm personally so committed to intervention for infants.

A handicapped child affects the whole child—the whole family. When my daughter-in-law had to be hospitalized, and this is common among parents of handicapped children, I cared for my grandson. I was afraid to sleep for fear I would not hear the child when he needed attention. My husband, who was dying of cancer at the time, forced himself to stay awake for brief periods so I could sleep soundly.

Those who have never had to live through it will never know the personal and family toll that a handicapped child can make. Much can be alleviated through family based flexible intervention. Research shows that the children whose parents are given skills to help with their children will make greater gains than those without the parent component.

Flexibility must allow for unusual hours to meet with the family and for all types of parents. Parents will include a middle class, well educated and interested group, and it will also include parents with little or no education, a lack of parenting skills, few resources and a love for the children but little interest in them.

Parents who are still themselves children with needs of their own and few skills present a group with increasing numbers. Retarded mothers who themselves have been raised in institutions present another group. Parents who have had little tolerance and a potential for abuse to their children who fail to live up to their unrealistic expectations are another.

There must not be a single model but one that is as individualized for the parents involved as it is for the children. Certain safeguards must be taken: an assurance of family based programming with flexibility for staff to meet the parents and children; differentiated programs to meet individual needs; specific training for the parents; a variety of models to serve the children; and a multiplicity of personnel and resources to meet the various problems that will present themselves.

Assurance is also needed that State plans will include the definition of developmentally delayed children, and not insist upon a categorical label or model for service, that there will be a comprehensive effort to locate the children needing services, and that there will be as little time lapse as possible between identification and service.

While the same protection must be given these students as well as others under Public Law 94-142, time is particularly important with this age group. Trained personnel to work with the preschoolers is important, especially those working with infants. Methods and materials used for the 3 to 5 year olds are not appropriate for infants.

Nurses, physical and occupational therapists, social workers, educators, communication specialists and all others working with the babies need specific training for their areas of emphasis, and those working with 3 to 5 year olds should be given theirs, not a watered down version of what is given the school age child.

Protection should also be given to those programs that have already established expertise in working with infants and preschoolers. They should be allowed to continue their work. Often those new to the field believe they are offering an adequate program, because they don't know all aspects of a good one or aren't aware of the skills that they lack.

Assurance should be provided for the continuation of current quality intervention programs and the use of those professionals, either through contracted services or through some other means, to help educate those who are not proficient or expert in this area.

In conclusion, let me summarize by stating that early intervention works, it is cost effective. The earlier it begins, the greater the impact. The impact is also greater if the family is involved.

In order for it to be most effective, there is a need to have well qualified personnel to carry out the intervention.

As a representative of United Cerebral Palsy, I strongly endorse the concept of Senate bill 2294 and suggest the proposed changes attached to my written testimony to strengthen this critically needed legislation.

As a professional in the field, I join others to ask your support. As a parent and grandparent, I speak for others like me and plead for it to become law.

Mr. HAYES. Thank you, Ms. Hart. Mr. Oglesby.

[The prepared statement of Dr. Verna Hart follows:]

STATEMENT
RESPECTFULLY SUBMITTED
TO THE
SELECT EDUCATION SUBCOMMITTEE
ON THE HOUSE COMMITTEE ON EDUCATION AND LABOR
ON
SENATE BILL 2294 THE EDUCATION OF THE
HANDICAPPED ACT AMENDMENTS 1986

On Behalf of

United Cerebral Palsy Associations, In
1522 "K" Street, N.W., Suite 1112
Washington, D.C. 20005

Witness: Dr. Verna Hart
United Cerebral Palsy Associations, Inc.
Pittsburgh, PA

Accompanied by: Karen S. Franklin, Policy Associate
UCPA Governmental Activities Office

I am Verna Hart, a Professor of Special Education at the University of Pittsburgh where I coordinate the program in early childhood education for the handicapped. I am also testifying today on behalf of United Cerebal Palsy Associations, Inc. UCPA is a private nonprofit agency with over 220 affiliates in 45 states dedicated to meeting the needs of persons with cerebral palsy and similar disabilities. Since its inception, UCP has advocated for early intervention and preschool services for young children who have handicaps. In 1970, with a grant from the Department of Education, UCP assisted over 100 community agencies in 30 states establish intervention and preschool programs for young children with cerebral palsy and other severe disabilities along with gathering needed research information on the benefits of such programs.

I began my teaching career 38 years ago after earning a Bachelor of Arts Degree as a speech correctionist. I have taught all types of handicapped children, becoming certified in each of the areas of special education and earning a Master's of Education Degree in Deaf Education and a Doctorate of Education in Multiple Handicaps in the process. Currently, I am training teachers to work with young handicapped children, birth to two, with special emphasis on those who are multiply handicapped.

I formerly taught at Peabody College of Vanderbilt University where I I coordinated the teacher preparation program for multiple handicapped and deaf-blind, and where I first began work with handicapped infants on a formal, data basis. In such work, my staff and I found that the earlier you started intervention with physically and sensory handicapped preschoolers, the more gains they made. We also found that early intervention could be used as a preventative measure against the occurrence of multiple handicaps that result from inadequate environment handling and management. With the excitement of such information, I moved to Pittsburgh in 1972 when I was given the opportunity to pursue preschool education for the handicapped as my full time responsibility.

I must admit that I alone did not make the decision to pursue a career in special education. Brought up to believe that a woman should stay home wth her family while they were in their formative years, I had not planned on teaching following the birth of my children. However, my second child was born handicapped and the expense of maintaining that child not only put me back in the work force, but led me to take both full and part-time jobs to meet the cost of raising him. Thus, I can credit my thirty-two year old son who is now living independently in another state, for a position that I thoroughly enjoy. I can also credit him with teaching me most of what I know about exceptional children, for most of the information has not come from books.

To supplement the knowledge gained from raising my son can be added that learned while grandparenting two grandsons, one handicapped as a result of a "doctor's goof" and the other who became handicapped as a result of the birth of his younger brother. As a result, I have been a provider as well as a consumer of services to handicapped preschoolers.

One of the resources that I was able to use was United Cerebral Palsy.'' As an infant, my grandson was able to avail himself of the services that a transdisciplinary trained physical therapist was able to provide. However, my son was unable to obtain services until he was four years of age, when he received the "cerebral palsy" label that allowed him such aid. Fortunately, today most children can receive help when it is determined that they are developmentally delayed in the motor area. In some states, however, the same conditions exist as when my son was young and services are delayed until the cerebral palsied label is obtained.

As a parent and as a professional, I am committed to early intervention for handicapped preschoolers. Research shows that it does make a difference to the children involved. My doctoral students and I have been involved in a series of studies that show early intervention results in gains for all children including those children who entered our studies unresponsive to those around them. With appropriate intervention techniques and materials, used by a well-trained staff, all of the children were functioning at a higher level from when they began the studies. Early facilitative techniques in handling, feeding, dressing, and motor development; as well as supervised experiences in social, cognitive and language areas are able to prevent many of the secondary handicaps that so often accompany the primary ones.

As a parent and as a professional, I am committed to early intervention, but as a tax payer I also can see its value. While at Peabody, I carried out a study to see the effects of early intervention on the multiply handicapped children who had been referred to us because of lack of appropriate placement in other programs. After our early intervention, we were able to find less restrictive settings for all of them. One of the ways that we evaluated the program was to take the cost of their placement when they were referred to us, the cost of the placement in which they were subsequently placed, and figured the difference. We multiplied the amount by the number of years between the children's ages of placement and their sixteenth birthday, figuring they would be in school at least that number of years. We found that the program more than paid for itself in the savings projected.

On a personal basis, early intervention really paid off, for my son was taken from an institution for the retarded while still a preschooler educated in special education classes at ages four and five, and then mainstreamed with his neighborhood friends for the rest of his education while he was a preschooler, my husband and I spent the money that we had put aside for college for our four children, thinking that our son needed it more at that time and that he would never attend an institution of higher education. How pleased we were when he was accepted into college and really elated when he was pledged to a fraternity. You can see why I believe in early intervention!

Early intervention also benefits the family of the child involved. Most parents do not choose to have a handicapped child. In most instances, they would choose not to. Most families prepare for the birth of a normal child and are shocked when informed that the child has problems. They still prefer to think of a normal infant. I was among them. Even though I knew that my daughter had exposed me to rubella while I was pregnant, I had taken the accepted preventative measures and had shots of gamma globulin. While it undoubtedly helped with the severity of the handicap, it did not prevent it. Just like the parents who are unprepared for the appearance of a handicapped newborn, I was shocked.

I was also shocked when my second grandson was delivered prematurely by Caesarean Section. I, who had made many trips to the neonatal intensive care nursery to see other babies, had a hard time seeing "our" baby among the many machines and tubes used to help him breath. My daughter-in-law was even more upset, for she had never been exposed to the sight of a new-born nursery for premature infants. She fainted. My son was stoic, worrying first about whether the baby would survive and alternately about how he would pay the hospital bill.

The most devastating reaction was shown by my seventeen-month-old grandson when the baby finally was brought home. The first-born grandchild on both sides of the family, this happy, outgoing child reacted to the newborn with great dislike. Formerly taken everywhere by his doting parents, he no longer was allowed out of the apartment because the newborn baby needed to be in cold mist in order to breath. The baby also had to be where there was electricity available, for he had a tracheostomy and the tube had to be suctioned regularly to prevent his suffocation. It took both parents to care for the infant and the toddler was left to fend for himself. Understandably, he stopped talking and began to show temper tantrums and other acting out behavior, most of it directed toward the new baby. When the baby died in his sleep, 22 months later, he thought he was responsible. He still carries the guilt and the impact of those early experiences.

Most handicaps are not readily identified at birth, however, but begin to manifest themselves over a period of time. I have heard many mothers of handicapped infants express their dread of taking their babies to their doctors because each time they hear that something else is wrong. The doctor may inform the parents or the parents may be the ones to observe that all is not well. Parents look for intactness of their children, they read child development books and compare what they see with what they read. They compare their infants with others their ages, they listen to their mothers and to their grandmothers when they voice concerns. They fear something is wrong and yet they are upset when their fears are confirmed. It is at this time that support for the family is very important.

Support for the family is particularly essential at six periods of the child's life: At the time of initial diagnosis; when the child is first enrolled in early education; when the child is the age to normally attend school with neighborhood peers; at the entrance to the adolescence years when the discrepancies between the behavior of the child and the neighborhood peers become readily apparent, during the transition period when decisions must be made regarding movement from the sheltered environment of school into the world of work, and again when the parents become too aged to physically care for their offspring. It is important to note that this bill addresses four of these areas when support to the children and youth and their parents is so critical. Support of these times can truly benefit the children and parents but there is also a benefit to society.

If all the variables are controlled when studying the effects of early intervention, such intervention is cost effective. The graduates of such programs become contributing members of society with less special education required, greater income as adults, they stay in school longer, there is less contact with the police, they are more apt to go on for higher education, and they are more apt to become tax payers. It is also the mark of a civilized society that its less fortunate members are cared for and that all members of that society have rights as members of that society. Preschool handicapped children also have rights within that society and this bill is an opportunity to show commitment to that small minority within the larger group, a minority unable to fend for itself.

I'd like to discuss the legislation as it affects the two groups of preschoolers, infants and the 3-5 group. Only 25 of our states are currently providing services to preschool children. I happen to live in one of the states that has neither permissive nor mandatory legislation to spend state educational money for children less than school age. I daily see the result of such lack of legislation. Although all children have the same basic rights, many are penalyzed because of where they reside. They must wait until the mandated age until they can avail themselves of services. Precious time is lost and it takes longer to deal with their problems, for what once was a simple matter has become ingrained with age and habit. Multiple handicaps occur. Families fall apart.

I personally know the impact of trying to find a program for my son when there was none available. Twenty-odd years ago, I had to get up early enough to dress and feed three preschoolers and a newborn baby and be on the road in order to drive my son to the next community in time for an 8:30 class. It meant that I had to prepare my children's lunches to eat in the car because we would not be back before lunch. I had to drive back to the end of the kindergarten bus line so that I could put my oldest child on it for her afternoon class and then drive back to pick up my son. It meant that my children spent hours in the car every day.

I thought times had improved and this was a practice no longer necessary, but traveling around the country for in-service training sessions and working with parents and preschoolers in workshops set up for that purpose, I find in many places that time has stood still and the circumstances I went through as a parent in the fifties are the same for parents today.

My grandson is a case in point. We could find no appropriate placement for him. Programs refused him admission. Through professional contacts, I was able to find him a class within Pittsburgh. This meant that my son and his wife had to sign over the responsibility of their son to me. My grandson came to live with me. He stayed for a year and a half. In time, my son was able to find a job in a city that had a very high unemployment rate and moved his family so that my grandson could again return home. This has been at a cost to my son and his wife, both emotionally and financially. It is still difficult for the family, for my grandson would much prefer to live with his doting grandmother and aunt than at home where he has to compete with two precocious normal siblings and he doesn't hesitate to let this fact be known.

How many three to five year old handicapped preschoolers have grandmothers where they can move to obtain service? Most will remain without services during those vital years. Prior to the passage of P.L. 94-142, I saw many injustices to school age children as I traveled across the country. I see the same injustices today in the preschool population.

It is tragic to see immediate needs that must wait years before they are met. These children have the same rights to the benefits of our society as older children but must wait to obtain them. My heart goes out to parents who recognize the needs of their children but are powerless to obtain help for them.

The proposed legislation can prevent such injustices within a very short time. Three years has been proposed for implementation. Such an implementation time is more than realistic, for all states have been involved with planning grants for providing preschool services to handicapped children. Some states could implement their program earlier. None should be allowed a longer time. We all tend to put off until the last deadline is given but we manage to meet earlier ones that are mandated. There is must to be lost and too many will suffer if we delay.

The term "developmentally delayed" referring to those to be served seems particularly relevant. The University of Pittsburgh was funded to compile a State of the Art/State of the Practice resume regarding research in various areas of special education. I chaired the Working With Infants group and the problems in the various states that require special education labels prior to serving the children rose time and again during the discussions and debate. It is difficult to place labels on children during their early years. My son had six different labels while in preschool. My grandson has had four and is currently being processed for another label change. Unrealistic rules can interfere with services, and our preschoolers need immediate help, not delays

"Developmentally delayed" is most appropriate for the birth to two group also, for early diagnosis is difficult. We recognize that a child is delayed, but labels are difficult to place because of the changing nature of the children. Even within the area of cerebral palsy, there is difficulty. A child who is hypotonic, or low tone, in the first two years may become a spastic cerebral palsied with high tone, athetoid cerebral palsied with low tone, may remain low tone, or the tone may normalize. With deviations in low or high tone, early intervention may aid normalization in that tone. I can use my second grandson as a case in point.

Because of his prematurity, my grandson had been intubated to aid his breathing. Later, it was necessary to do a tracheotomy, a placement of a breathing tube directly into his trachea, because the tubing down his throat had caused a constricture and his trachea was not open enough to breath. He also had very high tone and was unable to flex into the normal floppy pattern of normal newborns. Instead of curving over the should when he was burped, he arched backwards. He had projectile vomiting, you could hear each breath he took, he often stopped breathing and had to be moved to begin again, and there was no visual response in the left eye. His was not unusual behavior among premature infants who have had a rocky road to survival. From the time he came home from the hospital, I kept a close eye on his development. His mother, who had had a previous child to compare him to, also recognized his problems. My daughter, who has worked for years with premature infants, also was involved. We all agreed that the child was not progressing normally, but the doctor insisted that his behavior was not unusual and that he would outgrow it. As the doctor who had brought her son through his initial illness, my daughter-in-law went along with him until the infant was eight months old. At that time, the baby was not able to hold up his head, something normal children do by four months or so. We changed pediatricians. Upon the initial examination, the well-trained doctor observed the same behaviors that we had observed. She wrote a prescription for physical therapy and private intervention sessions began that week. Within one month, the child was not only holding up his head, he was sitting independently, something that normal babies do at that age. Following his therapy, motorically he became a normal child and sessions ceased. If he had not had such intervention, abnormal motor patterns would have become ingrained, asymmetry would have resulted, muscles would have become contracted, muscles would have atrophied from lack of use, and the child could have had motor problems for the rest of his life. This is why I personally am so committed to intervention for infants.

Professionally, I can relate similar stories. We saw a four month old child last November. He had such high tone that he was unable to move. He could not even open his mouth and had to be fed by a tube down his nose and into his stomach. His hands were fisted and could not be opened. He did not respond to either auditory or visual stimulation. He was totally nonresponsive to his unwed, welfare supported mother who had four other children at home. Hopeless? Never! This child merely presents the need for a variety of personnel having input into the intervention program. In December, we brought this mother, infant and sister into our training sessions for the transdisciplinary professionals. The infant became one on whom the students in training practiced. The mother, bright and alert, picked up all the tips being passed on to the students. She asked intelligent questions. She took her child home and practiced the techniques given to her. She returned again in January for a couple more sessions. The child was less tight, he was beginning to respond visually, he was able to move his eyes when positioned correctly, he could open his mouth enough for us to assess its adequacy. In April they returned again. The child was much easier to position, he responded to his sibling, he was easier to handle, dress and feed. Mother reported that he was then able to eat hamburgers and french fries. This child is a spastic cerebral palsied child who is probably also deaf and retarded. He is also a member of an extended family where they all love him and where mother has passed on her training so that they all know how to handle him. He is valued. He is making gains. His mother will resist all attempts to institutionalizing him but will keep him an integral part of his family. That's what early intervention is all about.

Most cerebral palsied children are multiply handicapped and in need of total programming to meet their needs. A variety of interveners must contribute to the plan, all contributing their area of expertise. Early attention to vision, hearing, seizures, intellectual stimulation, and normalization of movement patterns can lead to prevention of problems or the lessening of those that already exist. Feeding and sleeping problems are early manifestations of problems. My son, as a newborn and throughout his preschool years, never slept more than four hours a night. As a chandelier swinging child who could climb up the draperies and cross the rod before he could walk, I could not sleep either. I gave up my sleep in order to protect my child and my home from the plugged in iron on the living room carpet, the removal of all the food from the freezer and the four a.m. sojourn when a milk chute was used to escape into the night and an alert neighbor three blocks away alerted us. Although my son slept too little, other infants may sleep too much. Still others may be such tremendous feeding problems that they take hours to feed. I remember one spastic child whose mother took eight hours a day to feed him by dripping food down his throat. Aspiration pneumonia was a frequent problem. Once we showed her how she could feed him in a much more efficient and less harmful manner, she stated that she didn't know what to do with her new found time. She used it by interfacing with her normally developing four year old who had previously been ignored.

Thus, it is not the child alone who is affected. A handicapped child affects the total family. At one time my biggest desire was to be able to shower without one hand through the shower curtain to keep the child from getting into difficulty in the brief period of time it took him to get clean. When my daughter-in-law had to be hospitalized, and this is a common occurrence among parents of handicapped children, I worried about running water, frying bacon and using the microwave because the sounds might mask the monitors or need to suction. I also was afraid to sleep for fear I would not hear the child when he needed attention. My husband, who was dying of cancer at the time, forced himself to stay awake for brief periods so that I could sleep soundly. Those who have never had to live through it will never know the personal and family toil that a handicapped child can make. Although there may be situations that will bring joy, there will be natural periods of anger, frustration and fatigue.

Early feelings of guilt, anger and incompetency can be alleviated through intervention. Parents can be given techniques to aid their child and will begin to feel more competent in the care of their child. However, the intervention must be family based and flexible enough to meet the needs of the child. Some families will be able to meet within the typical work hours of the intervener. Others will need to meet in the evenings or on the weekends. Flexibility is essential if the families are to be served.

Family intervention is necessary. Research shows that the children whose parents are given skills to help with their children will make greater gains than will children who are worked with without the parent component. Flexibility in the intervention must also be made to account for all the types of parents that will be encountered. The variety of parents will include a middle class, well-educated and interested group with good intentions. It will also include parents with little or no education, a lack of parenting skills, few resources, and a love for the children but little interest in them. Parents who are still themselves children with needs of their own and few skills present a group with increasing numbers. Retarded members who themselves have been raised in institutions present another group. Parents who have little tolerance and a potential for abuse to their children who fail to live up to their unrealistic expectation are another. There must not be a single model, but one that is as individualized for the parents involved as it is for the children.

To meet the needs of both the children and their parents, certain safeguards must be taken. There needs to be an assurance of family-based programming, with flexibility for staff to meet with the parents and children, differentiated programming to meet their individual needs, specific training for the parents, a variety of models to serve the children, and a multiplicity of personnel and resources to meet the various problems that will present themselves.

A needed safeguard is an assurance that state plans will include the definition of developmentally delayed children and not insist upon a categorical label or model for services in order to aid the children, that there will be included as a comprehensive effort to locate the children needing services, and there will be as little time lapse as possible between identification and service. While the same protection must be given these students as to all children under P.L. 94-142, time is particularly important with this age group. The children change much more rapidly and personnel working with them should be alert to those rapid changes.

Trained personnel to work with the preschoolers should be assured. Of particular importance is the need to prepare personnel to work with infants. There is a specific body of knowledge needed to work effectively with them. Methods and materials used for the three to five year olds are not appropriate for infants. Nurses, physical and occupational therapists, social workers, educators, communication specialists and all others working with the babies need specific training to insure their needs are met. In a survey conducted for the state of the art/ state of the practice integration papers previously referred to, it was found that those who are preparing personnel to work with infants believe there is a distinct body of information to be imparted to their students but their curricula do not differentiate from preschoolers in the actual training. This should not exist. Those working with infants should be trained for their area of emphasis and those working with three to five year olds should be given theirs, not a watered down version of what is given the school age child.

Protection should also be given to those programs that have already established expertise in working with infants and preschoolers. They should be allowed to continue their work. Often, those new to the field believe they are offering an adequate program because they do not know the contents of a good one. Personnel think they are providing expert services and aren't aware of the skills they lack. Assurance should be provided for the continuation of current quality intervention programs and the use of those professionals, either through contracted services or through some other means, to help educate those who are not proficient or expert in this area.

In conclusion, let me summarize by stating that early intervention works. It is cost effective. The earlier it begins, the greater the impact. The impact is also greater if the family is involved. In order for it to be most effective, there is a need to have well qualified personnel to carry out the intervention. As a professional in the field I join others to ask your support. As a representative of United Cerebral Palsy, I strongly endorse the concept of Senate Bill 2294 and suggest their proposed changes to strengthen this critically needed legislation. As a parent and grandparent, I speak for others like me and plead for this early childhood initiative to become law.

Proposed UCPA Changes to the Senate Bill 2294
The Education of the Handicapped Act Amendments of 1986

Early Intervention Council, Section 624

a. The board shall include not less than three individuals representing state and local private nonprofit agencies who are involved in or concerned with the needs of infants with handicaps, and not less than three individuals who are parents of infants with handicaps.

b. The early intervention council shall:

Ensure that efforts are made to promote the use of existing public and private early intervention programs and private early intervention programs and develop cooperative agreements between the designated state agency and private nonprofit early intervention programs currently providing services.

Program Components Section 625

The definition of early intervention should be defined as a program serving all infants with handicaps from birth through age two, within the state. Such programs shall provide each infant with a handicap individualized services designed to reduce or amelorate the effects of the handicapping condition. The program shall include family services and parent training, and when appropriate, such services shall be provided in the home and/or in community-based centers. Program services shall be provided on a full year basis, when appropriate.

The term "infant with handicap" should be expanded to mean an individual from birth through age two who is substantially developmentally delayed or who has a high probability of becoming substantially developmentally delayed or who has specific congenital or acquired conditions and by reason of such requires early intervention

Parent Information and Training Programs 641

The Secretary shall ensure that at least one grant under this subsection is funded in each state. As possible, the Secretary shall make additional state grants under this subsection to reflect unserved geographic areas and underserved populations.

Authorization of Appropriations for Parent Information and Training Programs

There are authorized to be appropriated to carry out the provision of this part, the greater of $10,000,000 or 10 percent of the authorization of the appropriations for Part D - Training Personnel. This will ensure the funding of at least one center in each state.

TESTIMONY OF JAMES R. OGLESBY, SECRETARY/TREASURER, NATIONAL SCHOOL BOARDS ASSOCIATION

Mr. Oglesby. Thank you. Mr. Chairman and members of the Committee, I am Jim Oglesby. I'm the Secretary/Treasurer of the National School Boards Association. I'm an elected school board member in Columbia, Missouri, and my paying job is with the University of Missouri in Columbia as an administrator and a faculty member in the College of Education.

The National School Boards Association supports a strengthened commitment by all levels of government to provide special services for children from birth to age 5. Within that framework, we believe that there is an appropriate role for local boards of education, as well as for the Federal Government.

In passing S. 2294, the Senate built this legislation around the possibility that there may be as many as 600,000 unserved special needs children in the age range 3 to 5. Further, the Senate determined that full service for this age range would cost approximately $2.7 billion annually.

N.S.B.A.'s testimony deals only with those in the age range from the 3 to 5 population. Under no circumstances do we believe that we can be the primary provider in school districts to serve infant age children. N.S.B.A. will not support legislation which identifies school districts as lead agents or which otherwise mandate key responsibility for school districts in the birth to 2 age range.

With regard to the 3 to 5 age range, if the subcommittee believes that legislation is required, we must recommend against a simple extension of Public Law 94-142 mandated for this age group. We strongly believe that there are compelling factors which led to Public Law 94-142 whose enactment N.S.B.A. actively supported and are not present here in terms of legal equal protection underpinning or the program focus to educate school age children.

Accordingly, we recommend a different type of Federal program with a different type of Federal commitment. We offer two program approaches.

First, if the Congress seeks to mandate services, we believe that it should fully fund the programs through a judicially enforceable entitlement program. Ample precedence exists to support an entitlement program of this size to address these types of needs.

In this regard, we urge the committee to consider the establishment of a dedicated funding source. Again, ample precedence exists in the school district setting, such as custom duty supporting the school lunch program and severance receipt supporting the in lieu of tax payments.

In urging that any mandate program be driven by entitlement payments, our written testimony points to the fiscal reality of mandating expenditures in the billion dollar range. For example, at $2.7 billion this program represents about 30 percent of the annual average increment to school district budgets. With the reform movement currently generating a 7.2 percent increase in expenditures, we believe that State governments will give us no more money or will they allow our voters to increase our taxes.

As Mr. Coleman, a member of your committee, knows, in Kansas City, Missouri voters have consistently turned down attempts to increase their taxes. Further, we have confronted with us new economic realities. I'd like to list a few of those for you.

State reform improvement mandates pose very expensive service expansions to school district budgets, such as staff salaries to attract quality teachers to the teaching profession and, in some cases, States have already implemented early childhood programs.

Other recent Congressional mandates, as well as court ordered mandates. The withdrawal of Federal assistance not only has the purchasing value of categorical programs shrunk by 30 percent, but other State and local governments which support school districts are also cutting back. If Gramm-Rudman automatic cuts are reinstituted, then a $200 billion deficit would yield another 20 percent cut.

The tax bill pending would cost school districts hundreds of millions of dollars in lost arbitraded income on their bonds and may raise the bond management costs millions more. Farm, oil, and mineral States are suffering to the point of threatening to cut existing program budgets.

Restated, school districts do not have the revenue raising capacity to fund full services contemplated by S. 2294. Thus, any mandate spells a preemption of programs for school aged children in favor of services for preschoolers. Principally and fiscally, we strongly believe that any Federal mandate in this area must be fully funded through an entitlement program.

On the other hand, if Congress is not willing to finance a mandate yet wishes to legislate, we suggest the establishment of a two component grant in aid program totally apart from 94-142.

The first component of this approach would be a large local formula grant program which would be a permissive maintenance program generally utilizing a Chapter 1 type of delivery system. The second component would require a capacity building program to assist school districts with a start-up cost such as facility preparation, acquisition of program equipment, transportation capacity and staff development.

Additionally, if the subcommittee is determined to place new responsibilities on school districts, we urge other types of protection. For example, other State and local units of government should not be permitted to withdraw their support of these special service programs. As the Subcommittee recalls, this was exactly our experience in the area of related services under Public Law 94-142.

Further, we urge the Committee to seek adequate insurance protections for school systems in terms of unfavorable practices in the area of rates, coverage and insurance management, as well as exculpatory language which the insurance companies of parents could be relieved of payment.

We have a number of substantive concerns over S. 2294. For example, if the term developmentally delayed becomes a criterion for service eligibility, that term should be defined and should require the identification of at least two developmental factors. In this regard, we are necessarily concerned that school districts will be required to expand our responsibility to serve purely medical cases as well as feeling both the legal and political pressure to extend the limits of developmental delay to a broader base of children who lack pre-readiness skills.

Second, regardless of the amount of Federal funding, a phase in period would be required in terms of building programs, staff development, staff recruitment, funding, preparing facilities, obtaining equipment and appropriate transportation.

Third, because the legal and educational connection between school house and the school aged children is not present for preschoolers, we urge that legislation include alternatives for designating other State and local agencies as lead agents with the primary responsibility for providing this special service.

Schools run the risk of being perceived as providers of daycare services. Finally, we urge the subcommittee to study the cost of providing the service. While we do not know the basis for the Senate's estimate of $2 billion, we question as to whether it is taken into account all nonprogrammatic costs such as transportation, construction and the extra cost of Federal compliance.

Likewise, we question whether it reflects current fiscal trends such as professional salary level increases resulting from State reforms and rising insurance costs, or whether it accurately identifies the number of children who are likely to be classified as developmentally delayed.

In conclusion, N.S.B.A. supports more programming for the 3 to 5 year olds. However, the cost of the practical, educational and legal distinction between serving school age children and the 3 to 5 year olds, a simple extension of Public Law 94-142 is not a correct solution.

Rather, we support an enforceable entitlement program, preferably with a self-executing or a dedicated funding mechanism. To the extent that Congress is not prepared to undertake that commitment, we urge apart from 94-142 the development of a local, large, formula driven, discretionary grant program of maintenance and capacity building.

Thank you very much.

Mr. HAYES. Thank you.

[The prepared statement of James R. Oglesby follows:]

NSBA
FEDERAL RELATIONS

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TESTIMONY

on behalf of

THE NATIONAL SCHOOL BOARDS ASSOCIATION

on

EDUCATION OF THE HANDICAPPED AMENDMENTS

before the

SUBCOMMITTEE ON SELECT EDUCATION
of the
COMMITTEE ON EDUCATION AND LABOR

U.S. House of Representatives
2257 Rayburn House Office Building

July 24, 1986

Presented by

James R. Oglesby
Secretary/Treasurer, NSBA

Also present for NSBA:

Thomas A. Shannon
Executive Director

Michael A. Resnick
Associate Executive Director

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I) INTRODUCTION

I am James R. Oglesby, Secretary-Treasurer of the National School Boards Association (NSBA) and a school board member from Columbia, Missouri. I am pleased to have this opportunity to testify before the Subcommittee on Select Education. The National School Boards Association is the only major education organization representing local school board members, who have the responsibility of governing the nation's public schools. Throughout the nation, approximately 95,000 of these individuals are Association members. These people, in turn, are responsible for the education of more than 95 percent of the nation's public school children.

Currently marking its forty-seventh year of service, NSBA is a federation of state school board associations, with direct local school board affiliates, constituted to strengthen local lay control of education and to work for the improvement of education. Most of these school board members are elected public officials. Accordingly, they are politically accountable to their constituents for both education policy and fiscal management. As lay unsalaried individuals, school board members are in the rather unique position of being able to judge legislative programs purely from the standpoint of public education, without consideration to their personal professional interest.

At NSBA's annual convention last April, our representative Delegate Assembly adopted two resolutions pertaining to federal legislation which mandate services under P.L. 94-142. The applicable portions of those resolutions are set forth in Appendix I of our statement.

II) OVERVIEW: SUPPORT FOR STRENGTHENING EARLY CHILDHOOD PROGRAMS

At the outset, I wish to emphasize that NSBA supports a strengthened commitment by all levels of government to provide special programming for handicapped children within the birth and 5 year-old range. For many handicapped children, the earlier such services begin, the better off the children and their familes will be in dealing with, and overcoming, their disabilities. According to data contained within the Eighth Annual Report to the Congress, 259,000 handicapped children, ages 3-5, received services in the 1984-85 school year. While this represents a 32.3 percent increase from eight years ago, the Senate estimates that perhaps an additional 600,000 children, ages 3-5, may still need services. Financially, with service costs averaging several thousand dollars per child, full service to the entire 3-5 age group would require several billion additional dollars per year.1/

We view the tasks before the Subcommittee as: 1) determining whether needs can be clearly defined; 2) determining whether the federal government can fashion an effective delivery system; and 3) determining the extent to which federal financial assistance is warranted. In this regard, we commend the Chairman and members of this Subcommittee for holding this series of hearings. Inasmuch that the Senate-passed bill (S. 2294) would mandate a central role for local school districts in serving the age 3-5 population, we believe that the Subcommittee is being prudent in taking the time to consider the feasibility of that Bill, as well as to explore other approaches to serving the pre-school handicapped population.

If the Subcommittee concludes that legislation is needed we urge that it not view its mission as one of simply extending the P.L. 94-142 mandate for the school-aged population to pre-school children. Services for such children are tied to a different legislative rationale, a different program focus, and other distinguishing factors which we believe requires a different program and a different federal commitment.

The first area I would like to address is the matter of funding.

1/The thrust of our testimony focuses on programming for the 3-5 age group -- although we express serious concern over any federal program which would designate school districts as the primary agency for serving the infant age range; i.e., birth to two.

III) FUNDING: THE FISCAL IMPACT OF S. 2294 ON LOCAL SCHOOL DISTRICTS

A) Senate Cost Estimate Questionable

If funding were not a concern, the task before us would be much simpler. In the report accompaning S. 2294, the Senate Subcommittee estimated the annual cost of servicing the 3-5 year old population to be in the range of $2000 to $4500 per student — or $2.7 billion nationally. Based on anecdotal reporting by the NSBA membership that estimate is probably low. The explosion of insurance costs, the additional administrative and reporting requirements of P.L. 94-142, rising salary costs, the definitional aspects of the term "developmentally delayed", and other factors which we have summarized in Appendix II, would substantially increase the Senate's projected cost estimate — if the mandate of S. 2294 were enacted into law.

B) Relationship of Senate Cost Estimate to School Expenditures

But even using the $2.7 billion figure, that projected cost represents approximately 30 percent of the $9-10 billion by which total school district expenditures have increased in each of the last two years, and probably constitutes over 30 percent of the typical school district's real budget flexibility.2/ With school expenditures already increasing at the rate of 7.2 percent, it should not be assumed that school districts can automatically use existing revenue sources to fund this program.

Thus, the cost of this program would be impossible to accommodate without sacrificing some area of existing programs, or finding a new revenue source.

C) The Problems of Raising New Local Revenues

Unfortunately, the revenue raising capacity of local school systems is complicated by a number of additional long-term factors, all of which are relatively new. First, new local revenues are already being committed to other recent mandates. For example, the state reform movement has expanded unfunded financial mandates on local school systems — especially in the very expensive and fixed cost area of salaries. Second, the cummulative impact of other new federal mandates such as the Fair Labor Standards Act, asbestos abatement (pending), the extension of mandatory health and medicare coverage, etc., ... again, are presenting affected school districts with additional fixed costs.

Second, the federal government itself has been drying up as a revenue source; and further, it is acting to impede the revenue raising capacity of school systems. Over recent years there has been a significant withdrawal, in real dollar terms, in: a) direct federal assistance to school districts (about 30 percent decline in real dollars); and b) aid to those other state and local units whose dollars and services buttress the nation's schools.3/ Further, in the past few years, the federal government has cut off a variety of major cash-flow management practices that have generated substantial revenues and is now contemplating to go further. For example, depending on the shape of the tax bill pending in Congress, school districts could lose hundreds of millions of dollars in the increased cost of managing their bonds -- and already have effectively lost their ability to earn arbitrage income. Further, the potential revenue capacity of school districts could be jeopardized through the loss of sales tax deductibility.

2/Over 92 percent of school district budgets are viewed as "fixed" costs because they constitute legal obligations (e.g., debt service), mandates (e.g., state student/teacher ratios, asbestos abatement), or items which simply cannot be cut (teachers salaries).

3/In his statement of June 16, 1986 to the Subcommittee on Legislation and National Security, CBO Director Penner indicated that under a system of automatic spending cuts, a $194 billion base-line deficit level in FY 1987 would reduce non-defense spending by another 20.9 percent.

Third, the economies of a number of states are suffering, especially those states which are reliant upon agriculture, oil, and mining. Faced with deficit shortfalls, the immediate capacity of state government — and the willingness of local voters — to support new services through increased taxes is questionable. Indeed, currently school districts in oil states are considering budget cuts and layoffs. The financial solutions to their problems will extend over a period of years.

D) The Need for Adequate Federal Funding

In view of the financial magnitude of a pre-school mandate, we believe that the Subcommittee must take full notice of the fiscal condition of school systems by providing adequate and reliable federal funding — if it is going to legislate in this area.

IV) BASIS FOR ENTITLEMENT PROGRAM

NSBA strongly believes that any mandated program in this area must be financed through a judicially enforceable entitlement program.

A) Rationale for Entitlement Program

Our rationale is as follows:

1) Cost of the Mandate. As indicated, a mandated program, even limited to 3-5 year olds, would cost school districts and local taxpayers at least several billion dollars a year. The sheer size of this program justifies entitlement funding.

2) Weak Federal Commitment to Discretionary Appropriations. History has shown that Congress is not willing to live up to its funding commitments for special education. As members of the Subcommittee know, upon the original enactment of P.L. 94-142, a commitment was made to fund 40 percent of the excess cost of serving handicapped children. However, funding never exceeded 12 percent and at one point, slumped to 7 percent. Perhaps, it was this lack of confidence in the traditional appropriations process that caused the chief sponsor of the Senate bill, the Senate's most effective advocate for handicapped funding, to conclude that, even as a mandate, S. 2294 should not carry a promise for new appropriations. If the Congress, as a whole, is going to commit itself to pre-school handicapped funding, history suggests that it can only occur through entitlement funding.

3) Nature of the Mandate. For school-aged children, P.L. 94-142 mandates special education and related services in conjunction with the school systems' general obligation to educate all children ages 5-17. In the case of pre-school children, if a mandate for special services were created, it is not as an alternative for services which are available to the population as a whole. Nor, is it in the nature of redress for the denial of services available to other students. That is, the equal protection justification of the original federal mandate is not present — or, at least is not as compelling as a federal mandate for services to school-aged children — regardless of local cost.

In reality, a pre-school program would break with the original conceptual framework of P.L. 94-142, establishing a new precedent in the area of federally mandated services. As such, how would a federal mandate for pre-school handicapped services be distinguishable, as a matter of consistency and policy, from federally mandated pre-school services for limited English proficient pre-school children, or educationally disadvantaged pre-school children, or the population as a whole? While those services would have merit, we fully believe that if Congress is going to break into this new arena of mandate, it should obligate itself to provide the funds. Ironically, under S. 2294, the Congress' financial commitment to the program is less than the P.L. 94-142 funding level for school-aged children: it is zero.

4) Pre-emptive Impact on Programs for Students Age 5-17. As creatures of the state, the basic function of school districts is the education of children ages 5-17 -- including children requiring special education. Congress now seeks to extend this mandate beyond the legal age range. To the extent that school districts cannot raise new funding, the pre-school mandate will pre-empt those services that are necessary to meet the state defined mission of the school district. This pre-emption of resources for pre-school children is clearly distinguishable from the pre-emption that occurs currently under P.L. 94-142 between school-aged handicapped children and other students.

5) General Appeal of Entitlements. While some of the reasoning may differ, we do not expect that any responsible group in the public sector with a direct interest in supporting special education or the fiscal viability of our schools would seriously oppose the creation of an entitlement program.

B) Establishment of a Dedicated Funding Source

In conjuction with the creation of an entitlement program, NSBA would support this Subcommittee's efforts to work with other committee to establish a federally dedicated funding source. Not only are such dedicated sources already used for other entitlement programs, they are also utilized for other school district programs such as school lunch (e.g. customs duties) and the timberland and mineral receipts programs.

V) ALTERNATIVES TO AN ENTITLEMENT PROGRAM: INCENTIVE GRANTS AND INTER-AGENCY PROTECTION

To the extent that Congress is not willing to fully fund a mandated pre-school program, NSBA would support the following alternatives:

A) Incentive Grants

NSBA would support a major incentive grant program -- separate from P.L. 94-142 -- in the nature of local formula grants. In this regard, we would not recommend a grant program which left school districts without the effective option to reject participation in the program.

B) Inter-agency Protection

If a major federal grant is established, local school districts should be protected from other state and local agencies reducing or off-setting their current levels of assistance to local school systems (unless full funding is reached). Without such protection, the risk is created that federal incentive grants will become indirect payments for the benefit of other agencies -- and, in effect, reward their withdrawal of assistance. Members of the Subcommittee will recall that local school systems encountered that expensive experience when they assumed the obligation of providing related services under the current P.L. 94-142 program.

C) Federal Regulation of Insurance Practices

NSBA urges the Subcommittee to consider insurance practices as they pertain to the scope of coverage, rates, and management requirements on local school districts -- if school districts assume principal responsibility for serving 3-5 year olds. Likewise, we urge the Subcommittee to consider the potential for exculpatory provisions being included in policies purchased by parents, once public agencies are made responsible for providing services. In this regard, NSBA will support efforts by the Subcommittee to work with other committees (if necessary) to provide regulatory protection for local school districts.

VI) SUBSTANTIVE CONCERNS PRESENTED BY S. 2294 AND RELATED DELIVERY SYSTEMS

The delivery system set forth in the Senate-passed bill raises a number of substantive concerns which we urge the Subcommittee to consider.

A) Developmentally Delayed

The Senate introduces the term "developmentally delayed" as a criterion for determining the eligibility of children ages 3-5 for services under P.L. 94-142. The rationale for using this standard is that it enables children to be identified without requiring categorical labeling by disability. Although there is no consensus as to the meaning of the term, special educators advise us that under current practice, children who are actually served under the developmentally delayed classification are the most severe and obvious cases.

NSBA's concern, however, is that by making this undefined term a legally enforceable right, a substantial amount of litigation will arise over the inherent ambiguity in the terminology. Although the Senate report does refer to the four developmental factors generally utilized by practioners, there is no such reference in the legislation itself. Further, in establishing child eligiblity the Senate report indicates that only one factor need be present; whereas, under current practice, usually at least two developmental factors must be present in determining eligibility for services. Absent a clear definition of this term, a much broader base of students will be seeking service than what we think is intended. Certainly, as the limits of this undefined term are tested and extended, very quickly any child who lacks pre-school readiness could be eligible.

We definitely anticipate a merger with children who would otherwise be viewed as Chapter 1 eligible students. This concern is heightened by the rising cost of day care services generally, as well as with the recent closing of many service providers which fail to meet standards for insurance purposes. On a more general level, local school boards are concerned over the day-care and early educational implications which legislation in this area will have on parents of non-handicapped children, or on parents whose children need minimal services. The question here is not whether society should serve all of these children, resources permitting, but what are the limits of this legislation? Accordingly, if the Subcommittee intends to use "catch-all" terminology, we urge that careful study be given to defining the meets and bounds of its applicability.

B) The Need to Phase-in Services

In the event that any legislation is structured as a mandate, NSBA strongly recommends that there be a phase-in period of several years. Certainly lead time should be available for those school districts which currently lack the programs and professional staff to address the needs of the 3-5 year old group. Further, many school districts will experience other start-up activities which are expensive and require lead time — such as finding and funding facilities, obtaining equipment, and acquiring appropriate transportation. In this regard, we urge that any legislation include a special grant program to help finance start-up costs.

C) The School District as the Lead Agency

Under P.L. 94-142, the school system assumes central responsibility for developing and financing the school-aged child's Individualized Education Plan (IEP). The law is clear as to the educational focus of the IEP, as well as to the requirements to provide "special education" and to do so in a "least restrictive environment". In terms of the school districts' obligation to serve the general school-aged population, and, in terms of bringing the great majority of special-education into the general program, the rationale for designating the school system with primary repsonsibility is compelling. However, the application of P.L. 94-142 concepts to the types of programs and environmental setting for pre-school children is not so compelling. We recommend that if school districts are generally given primary responsibility for the program — that, absent adequate federal funding, it be permissive responsibility — as well as include an option for state and/or local officials to designate an alternative primary agency.

D) Program for Children Age Birth to Two

In dealing with the population from birth to age 2, the Senate-passed bill authorizes the state to designate a lead agency — rather than specifically identify the school district with prime responsibility. If the Congress wishes to establish a program for that age group, NSBA would be opposed to school districts having primary responsibility. The nature of service for infants, including the nursery and day-care types of activities that are associated with each child in that age-range, is too far afield from the basic mission of school district to educate school-age children.

E) Attorneys' Fees

As the Subcommittee knows, NSBA vehemently opposes Congressional encouragement for lawyers to participate in the earliest stages of program development and discussions between parents and school officials. NSBA does not support the extension of recently enacted attorneys' fees provisions for the 3-5 year old population.

F) Funding from HEAD START and Other Sources

We are concerned that in funding this program, the Senate report at page 21 states that "other federally funded programs, such as Head Start, may be an additional source of funding for this age group." Without belaboring the point, suffice it to say that NSBA, as well as most other organizations comprising the education community, have a strong bias against taking money from one legitimate area of need to fund another.

VII. CONCLUSION

In conclusion, NSBA believes that society would benefit from a cooperative partnership by three levels of government to serve 3-5-year-old handicapped children. Within that framework, there is an appropriate role for local school districts, as well as the federal government. Because of the practical, education, and legal distinction between serving school-aged children and 3-5 year olds, a simple extension of P.L. 94-142 is not a correct solution. We believe that if the federal government is going to mandate service, then it must pay the cost through an enforceable entitlement program. To the extent the federal level is not prepared to fund its mandate, then we would recommend two grant programs: 1) a large local formula grant maintenance program — apart from P.L. 94-142; and 2) a capacity building grant program to assist such start-up activities as capital acquisition and personnel development. As the client agency of this Subcommittee, we would also recommend that any federal programs, which provide less than full funding, protect school districts against unfavorable insurance practices, as well as the withdrawal assistance by other state and local levels.

Again, I wish to thank this Subcommittee for the opportunity to testify.

APPENDIX I

NSBA RESOLUTIONS PERTAINING TO SERVICES FOR HANDICAPPED CHILDREN

2.1.1 Federal Participation in Education Funding. NSBA urges Congress and the President to continue a program of federal support for public elementary and secondary education that:

. . . D Recognizes that special needs assistance and general aid are appropriate federal activities—provided local control of, and accountability for, public schools are not usurped and local school board access to the federal decision-making process is assured. All costs of federally mandated programs and regulations must be fully financed by the federal government.

2.1.9 Education of the Handicapped. NSBA urges Congress to appropriate all funds necessary for school districts to meet the requirements of Section 504 of the Rehabilitation Act of 1973 and Public Law 94-142. . . .

NSBA opposes the payment of attorneys fees to prevailing plaintiffs when school districts, in making decisions on the appropriate education for the child, act in good faith and provide due process, as specified by law, to parents of handicapped children.

APPENDIX II

FACTORS IMPACTING ON COST ESTIMATES FOR PRE-SCHOOL SERVICES

We do not know the basis which the Senate utilized in estimating an average cost range of $2,000 - $4,500 per child. However, we expect that it has underestimated the cost of S. 2294 for the following reasons:

1) School District Insurance Costs. Insurance costs have exploded over this last year. In many cases, school districts are "going bare" (i.e., self-insuring). Private providers of pre-school services have been especially hard hit, including those who have arrangements with public schools. We suspect that the liability insurance costs for pre-school students requiring medical and related services have risen at especially high rates. In additional to general liability insurance, any mandate could also increase rates relating to errors and omissions and actions brought under §1983, 1988.

2) Since school districts do not provide full pre-school services, they will have start-up costs in such areas as construction, transportation, equipment, and staffing (professional staff, administrators, bus drivers, bus aides, etc.). Since as many as two-thirds of all eligible children are unserved, we suspect that these start-up costs were underestimated.

3) Even where school districts currently provide services, they do not necessarily utilize all the federally mandated procedures, serve all categories of students, or serve all students within categories. We suspect that additional costs would be involved, especially to the extent that current services are constrained by the marginal cost of expanding the number of students in the program.

4) Mandated services could increase a school district's share of the cost to the extent that other agencies withdrew assistance. Likewise, we would expect that federal mandates would alter insurance company contributions to total costs, as well as alter premium purchases by parents.

5) The total number of students seeking services could be influenced by definitions such as "developmentally delayed". In this regard, because of the unexpected number of day-care providers serving disadvantaged students that have closed, we expect that the volume of disadvantaged students seeking diagnosis and services was underestimated.

6) The state reform movement has substantially increased professional salaries, and will continue to do so — including the salaries of special educators.

Mr. **Hayes**. We have one more witness with this panel, Ms. Taylor. I would like the indulgence of the entire panel to permit us to go vote. The bell has already sounded. We have roughly 12 minutes left of the 15 minute call. I would suggest that we recess and you relax for these 15 minutes until we go vote and come back. It's part of our responsibility.

Thank you.

[Recess.]

Mr. **Hayes**. We'll resume our hearing. I do want to extend to the witnesses and to the interested people here in the hearing the apologies for the Chairman of our subcommittee, the gentleman from Montana for his inability to be here. He's required to be on the House floor pushing through some other phases of legislation that affect and impact on handicapped people. The bill before the House has to do with the allowance of legal fees for people to defend some of the positions we take here within the committee. That's the reason for his absence. I want you to know that.

So we'll now hear from the last witness of this panel, Ms. Ziegler.

TESTIMONY OF MARTHA ZIEGLER, EXECUTIVE DIRECTOR, FEDERATION FOR CHILDREN WITH SPECIAL NEEDS, BOSTON, MA

Ms. **Ziegler**. Mr. Chairman, it's an honor for me to accept the excuse of the Chairman this morning. I understand that this will be a very historic day for our children and families.

Mr. **Hayes**. That's right.

Ms. **Ziegler**. I slipped out hoping I could witness the vote and, of course, that didn't work out; and I appreciate your putting me back on the panel.

Thank you for inviting me to appear here today to comment on the pending legislation which holds out such great hope for handicapped children and their families.

I am speaking today on behalf of the National Network of Parent Centers composed of seventy-three centers now, which are operated by coalitions of parents representing a variety of disabilities. Most of the member coalitions conduct parent training and information activities through grants under Public Law 98–199, and a few operate with other resources, including State funding.

Forty-five States and territories are represented. Last year these parent projects served approximately 300,000 parents.

From my review of the literature and from my consultation with state agency and early childhood professionals, as well as parent leaders, it is very clear that we are way beyond the need for more demonstrations and more research about the efficacy of early education. Education and related services delivered from the earliest possible time of a handicapped infant's life benefit the child and the family and save public money in the long run.

Furthermore, parents want the tools that enable us to provide the best possible nurturing for our children from their earliest days. Study after study shows that handicapped children, no matter the nature or the degree of severity of the handicapping condition, require less intensive services during their school years than they would require had they not received help in those beginning years.

I have attached for the review of the Committee a brief description of the Colorado Research Design Study, and I especially call your attention to the charts that I found dramatically portray the educational and financial benefits of preschool programs for handicapped children.

I have also attached summaries of several major research studies on the efficacy of early education for handicapped infants. In addition to the findings of researchers, parents also can testify in a more personal way to the benefits of early education for their handicapped children.

Here are comments from just three individual parents:

"This invaluable program gave my son confidence in himself, and it has encouraged me and taught me how to help *him*."

Second one: "The program meant we were bonded even closer in working together to understand our daughter and each other."

And a third one: "It gave my daughter an education as well as playmates. It let the rest of my family know we weren't the only ones struggling to find answers or dealing with the day to day problems and heartbreaks."

The only question remaining is one of equity. Knowing what we know about the short and long term benefits of early education for handicapped children, how much longer can we go on denying those benefits to some handicapped children? Put another way: Why should we go on denying to certain States and localities the long range cost savings that occur when children need less intensive specialized services during their school years because they have had the benefit of early education?

We live in a mobile society. My own children have lived in three different States, none of them the State that either my husband or I grew up in. Our experience is not too unusual. At least we were able to exercise a certain amount of choice when we were confronted with each of these relocations. But many families today, including those with handicapped children, have no real choice about where to live.

Particularly vulnerable are the 10,000 military families with young handicapped children. When a young father serving his country is reassigned from Washington State to Georgia, what should he do? Leave his family behind without a father's presence so that their severely handicapped infant can go on receiving early intervention services? Jeopardize his long term military career by seeking what's called a compassionate assignment, thus getting permission to stay in the State of Washington so that his infant will be well served? Or should he cross his fingers, take the reassignment, move his family, and hope that Georgia will develop a program for his son before he is reassigned again?

No family should be forced into such hard choices, but least of all should our servicemen be placed in such a difficult position.

In addition to the national mandate, parent leaders across the country have indicated a number of areas of agreement which I would like to summarize.

Number one: Programs for handicapped children 0 to 3 years should include a strong primary component of family support. Karl

Kastorf, who is Director of the Early Intervention Program in the Massachusetts Department of Public Health, said to me, "The work of children 5 to 21 is learning, and of those 3 to 5, getting ready to learn. They do this in the mainstream of school and preschool. The work of children birth to 3 is development, and their mainstream is the family."

The purpose of early intervention is to assist the child and the family to help the child achieve maximum developmental potential. During these years, parents need unlimited amounts of information about their child, the role of the other family members, sources of help, program and treatment options, their rights and responsibilities as parents, and just sheer hope. They also need the skills that will help them become equal partners along with the many other care givers who will be dealing with their child over the years.

Second: Naturally, parents would like to see the new mandate become effective immediately, tomorrow. Nobody knows better than mothers and fathers how fast babies grow and how devastating the lack of services can be for the child and for the family. However, we recognize that some States will need time to change State laws or rules, and we also realize that there are critical shortages of trained personnel to carry out this mandate.

The two year time period allowed in the Senate bill seems to be a reasonable compromise. We suggest that some minimal start-up effort should be a requirement for all States participating in 94-142 starting in September 1987, and that all States be required to comply fully with a 0 to 5 mandate by September 1989.

Third: For children aged 0 to 5 years, generic terms such as developmental delay should be used, rather than the categories of handicapping conditions listed in 94-142. As the Colorado research study has shown, a sizeable percentage of the children served in early intervention and preschool programs will not need intensive special education later. These children should not be sigmatized by labels which are never as meaningful as they appear anyway.

Children meeting the technical definition of established biological or environmental risk should at least be screened and should be followed during the first 5 years of their lives, so that delays can be dealt with as they show up and as the children become eligible for services.

Fourth: We urge a strong unequivocal requirement for placement of these children in the least restrictive environment. As I indicated earlier, for children 0 to 3 years, least restrictive environment means maintenance within the family, and it also means acceptance of the individual family's culture and value system, including choices of programs that are home based, center based, regular daycare or other settings.

For children 3 years and older, L.R.E. means going to school or preschool or daycare alongside children the same age who are not handicapped. Most of the students referred to above—Most of the studies referred to above emphasized the added benefits that accrue for the handicapped child if early education occurs in a setting with ordinary age peers. We urge you to add the least restrictive environment requirement to each section of the new law.

Fifth: Parent leaders are unanimous in their view that all the provisions of Public Law 94-142 should apply to handicapped children ages 3 to 5, including the requirement that the State education agency serve as the lead agency. For infants ages 0 to 3 years, we could not reach agreement about the role of the State education agency or designation of a lead agency.

We did agree, however, that the law should require that every State plan include a component that assures smooth transition from early intervention programs to preschool and school. And we are concerned that the State plan should also require evidence that health, education and social service agencies are working together to serve these children and their families.

The increasing collaboration between the Division of Maternal and Child Health and the Office of Special Education and Rehabilitative Services at the Federal level serves as a model for the States in this kind of cooperation.

We also suggest that the Early Intervention Council and the Advisory Committee be folded together into one body.

Sixth: Parents are very concerned that the new mandate include appropriate standards for the personnel who will be serving these young children. Special knowledge and skills are needed in the areas of early childhood education, developmental psychology and special education.

Different sets of competencies are required for early intervention personnel, preschool teachers and elementary special and regular teachers.

Number seven, the last item: I ask you to add a section with an accompanying authorization of funds to include in this mandate the Department of Defense schools known as DODS, to ensure services for children in military families who are assigned overseas. I will be submitting another page of written testimony about this particular problem.

Only late yesterday afternoon did I have an opportunity to speak with a pediatrician at the Pentagon who gave me quite harrowing numbers about the problems of young handicapped children in military families overseas.

The debate is over. We know the benefits of early education for our handicapped children. For them, for their families and for society, I urge you to join the Senate in enacting a new national mandate so that Public Law 94-142 will serve handicapped children from birth through twenty-one years, no matter where in our country these young people reside.

Thank you.

[The prepared statement of Martha Ziegler follows:]

Statement of National Network of Parent Centers

To

Subcommittee on Select Education
Committee on Education and Labor
U.S. House of Representatives

In Regard To

Education of the Handicapped Amendments of 1986

July 22, 1986

Testimony Presented By:

Martha Ziegler
Executive Director
Federation for Children with Special Needs
312 Stuart Street
Boston, MA 02116

Thank you for inviting me to appear before you today to comment on this pending legislation, which holds out such great hope for handicapped children and their families. I am speaking on behalf of the National Network of Parent Centers, composed of 73 centers, which are operated by coalitions of parents representing a variety of disabilities. Most of the members coalitions conduct parent training and information activities through grants under P.L. 98-199, and a few operate with other resources. Forty-five states and territories are represented. Last year these parent projects served approximately 300,000 parents.

In preparing these remarks, with this Committee's list of questions as a guide, I have studied reports from the following agencies: The National Consortium of State Education Agency Early Childhood/Special Education Coordinators (1984); the National Center for Clinical Infant Programs (1984); TADS, University of North Carolina; the state departments of education in California, Washington, Colorado, and Massachusetts; and the Massachusetts Department of Public Health. In addition, I have conferred with leaders of parent coalitions in New Hampshire, Minnesota, Washington, and Georgia. These parents are Regional Directors of the TAPP Project (the technical assistance program for parent programs), and hence their views reflect their experience with parents throughout a whole region in addition to their own states. I serve on the advisory board of the Integrated Research Project and in that role chaired the two-day seminar on Handicapped Infants, one of the eight topics of the project.

From my review of the literature and from my consultation with state agency and early childhood professionals as well as parent leaders, it is very clear that we are way beyond a need for more demonstrations and more research about efficacy. Education and related services delivered from the earliest possible time of a handicapped infant's life benefit the child and the family and save public money in the long run. Furthermore, parents want the tools that enable them to provide the best possible nurturing for their children from the earliest possible days. Study after study shows that handicapped children, no matter the nature or the degree of severity of the handicapping condition, require less intensive services during their school years than they would require had they not received help in those beginning years. I have attached for your review a brief description of the Colorado Research Design Study, and I especially call your attention to the charts that dramatically portray the educational and financial benefits of preschool programs for handicapped children. I have also attached summaries of several major research studies on the efficacy of early education for handicapped infants.

In addition to the findings of researchers, parents also can testify in a more personal way to the benefits of early education for their handicapped children. Following are comments from three different parents whose children attended preschool:

> "This invaluable program gave my son confidence in himself. It has encouraged me and taught me how to help him."
> "It (the program) meant we were bonded even closer and working together...to understand her and each other."
> "It gave my daughter an education as well as playmates. It let the rest of my family know we weren't the only ones struggling to find answers or dealing with the day-to-day problems and heartbreaks of raising these children."

The only question remaining is one of equity: Knowing what we know about the short and long-term benefits of early education for handicapped children, how much longer can we go on denying those benefits to some handicapped children? Put another way, why should we go on denying to certain states and localities the long range cost savings that occur when children need less intensive specialized services during their school years because they have benefited from early education?

We live in a mobile society. My own children have lived in three different states, none of them the state that either my husband or I grew up in, and our experience is not all that rare. At least we were able to exercise a certain amount of choice when we were confronted with each of these relocations. Many families today, including families with handicapped children, have no real choice about where to live. Particularly vulnerable are the 10,000 military families with young handicapped children. When a young father serving his country is reassigned from Washington state to Georgia, what should he do? leave his family behind without a father's presence so that their severely handicapped infant can go on receiving early intervention services? jeopardize his long-term military career by seeking a "compassionate assignment" and getting permission to stay in the state of Washington so that his infant will be well served? or, cross his fingers, take the reassignment, move his family, and hope that Georgia will develop a program for his son before the father is reassigned again? No families should be forced into such hard choices, but least of all should our servicemen be placed in such a difficult position.

The debate is over; we know the benefits of early education for our handicapped children - for them, for their families, and for society. I urge you to join the Senate in enacting a new national mandate so that P.L. 94-142 will serve handicapped children from birth through 21 years, no matter where in our country those young people reside.

In addition to the national mandate, parent leaders across the country have indicated the following areas of agreement:

1. Programs for handicapped children 0 to three years should include a strong, primary component of family support. Karl Kastorf, Director of Early Intervention Programs for the Massachusetts Department of Public Health has said: "The 'work' of children 5-21 is learning, and of those 3-5, getting ready to learn; they do this in the mainstream of school and preschool. This gives an inherent focus and purpose to P.L. 94-142. The 'work' of children birth to three is development; their mainstream is the family." The purpose of early intervention is to assist the child and the family, to help the child achieve maximum developmental potential. During these years parents need unlimited amounts of information - about their child, the role of the other family members, sources of help, program and treatment options, their rights and responsibilities as parents, and just sheer hope.

We recognize that the Parent Training and Information Projects established under Part D of the Act can play an important role here in assistance to new parents, including referral to the appropriate disability organization. However, the parent projects will need more money to take on a new function. This is an area in which partnership funding might be encouraged; state education agencies, Regional Resource Centers, state Developmental Disabilities agencies, for instance, could help.

2. Naturally, parents would like to see the new mandate become effective immediately. Nobody knows better than mothers and fathers how fast babies grow and how devastating the lack of services can be for the child and for the family. However, we recognize that some states will need time to change state laws or rules, and we also realize that there are critical shortages of trained personnel to carry out this mandate. The two-year time period allowed in S. 2294 seems to be a reasonable compromise.

We suggest that some minimal startup effort should be a requirement for all states participating in P.L. 94-142, starting in September 1987, and that all states be required to comply fully with the 0 to 5 mandate by September 1989.

3. For children ages 0 to 5 years, generic terms such as "developmental delay" should be used rather than the categories of handicapping conditions listed in P.L. 94-142. As the Colorado research study has shown, a sizeable percentage of the children served in early intervention and preschool programs will not need intensive special education later. These children should not be stigmatized by labels, which are never as meaningful as they appear but are not at all helpful with very young children.

We suggest that this Committee look at the eligibility criteria used by Washington state as one possible model for a functional basis for eligibility. Children meeting the technical definition of "established, biological, or environmental risk" should at least be followed during the first 5 years in case delays show up and they become eligible for services.

4. We urge a strong unequivocal requirement for placement of these children in the least restrictive environment. For children 0 to 2 years, LRE means maintenance within the family and acceptance of the individual family's culture and value system, including choices of programs that are home based, center based, in regular day care, or other settings. For children three years and older, LRE means going to school, preschool, or day care alongside children the same age who are not handicapped. Most of the studies referred to above emphasize the added benefits that accrue for the handicapped child if early education occurs in a setting with ordinary age peers. We urge you to add the least restrictive environment requirement to each section of the new law.

5. Parents are tired of being shuffled from agency to agency; under P.L. 94-142, the old buck passing has nearly ended - parents have a one stop entry point throughout the handicapped child's school years. Every transition point is a painful period, and it is always worse when the child and family must also transition to a new agency. Parent leaders are unanimous in their the view that all the provisions of P.L. 94-142 should apply to handicapped children ages 3 to 5, and in about 40% of the states they already apply to these ages.

For infants ages 0 to three years, we could not reach agreement about the role of the state education agency or designation of a lead agency. We believe the SEA should play a major role, but not necessarily as the lead agency. In some states, a human service agency would be a better choice, and in others an Early Intervention Council would be better. Parents and early intervention providers should have a voice in this choice in each state. The law should require that every state plan include a component that assures smooth transition from early intervention programs to preschool and school.

6. Finally, parents are very concerned that the new mandate include appropriate standards for the personnel who will be serving these young children. Special knowledge and skills are needed in the areas of early childhood education, developmental psychology, and special education.

LIST OF ATTACHMENTS

A. "Programs for Handicapped Children," from "The Efficacy and Cost Effectiveness of Early Education for Handicapped Infants and Preschool Children," California State Department of Education, Sacramento, 1982.

B. "Colorado Research Design Study," from "Effectiveness of Early Special Education for Handicapped Children," A Report Commissioned by the Colorado General Assembly, 1982

C. Memorandum to Martha H. Ziegler from Karl Kastorf, Director of Early Intervention Programs, Division of Family Health Services, Massachusetts Department of Public Health

D. Graph Depicting Numbers of Children in SPED Preschool Programs in Massachusetts, 1974-83, Massachusetts of Education

E. Graph showing Average Costs for Children in SPED Preschool Programs in Massachusetts, 1974-83, Massachusetts Department of Education.

PROGRAMS FOR HANDICAPPED CHILDREN

Since 1960, early intervention programs for handicapped children have also increased in number. The variety of handicapping conditions, types of intervention approaches, and length of follow-up, or lack thereof, complicate the issue of the effectiveness of early intervention. Many studies involve small numbers of children; contrast groups are not used; specific intervention strategies are not delineated. For the sake of clarity, this writer shall address each handicapping condition separately and cite only those studies that have shown clear, methodologically sound results.

Mental Retardation

In a study by Fredericks (1980), a total of 151 moderately and severely retarded children ages nine to eleven in the state of Oregon were tested once a year for three years on the Student Progress Record. Sixty-eight children had received no preschool training; 35 had one year of preschool; 48 had two years of preschool. Fredericks found no significant differences in socialization scores, but did find a significant difference in language, academic, and motor development between those with two (2) years of preschool and those with no preschool. There were no significant differences between those with one year of preschool and those with no preschool. In the area of self-help there was a significant difference between those with two years of preschool and those with one or no years of preschool.

A survey of 88 percent of the Oregon school districts with TMR programs for the previous four years revealed that 131 TMR pupils had moved to resource rooms, EMR centers, or regular classes. Of the original 151 children, all but 11 had at least one year of preschool experience, 98 had two or more years of preschool. The results of the study may underestimate the results of preschool experience for TMR children since the higher functioning school-age children were not included in the study.

The results of Fredericks's study are important for three reasons. The study samples a large number of children. It follows the progress of the children in five developmental areas stressed in preschool for a three-year period, several years after the preschool training. It assesses the progress of children with different preschool experiences from different geographical areas of the State of Oregon.

Down's Syndrome

Hanson and Schwarz (1978) sought to "document the longitudinal development of 12 infants in an intervention program and to compare their development with previously established 'norms' for Down's Syndrome and normal children" (page 403). Six boys and six girls, diagnosed at birth, were the subjects. The children began the home-based parent training program between four weeks and six months of age. Parents were visited weekly or biweekly by a home trainer who provided daily step-by-step educational programs for the parent. Duration of participation in the program ranged from 15 to 30 months. Results showed that,

Copied from "The Efficacy and Cost Effectiveness of Early Education for Handicapped Infants and Preschool Children," California State Department of Education, Sacramento, 1982 in general, the infants in the experimental group reached developmental mileposts slightly later than normal infants but consistently earlier than Down's syndrome infants who were not involved in an intervention program.

Blind Children

Selma Fraiberg has completed a number of longitudinal studies of infants blind since birth (Fraiberg, 1968, 1975, 1977; Fraiberg and Freedman, 1964; Fraiberg, Smith, and Adelson, 1969). Results indicate that typically a large percentage of blind children show severe autistic-like behavior, have no significant human ties, have echolalic (if any) speech, have no definition of body boundaries, persist in motor stereotypes of the head and hands, and have often not achieved mobility (Fraiberg, 1970). Ten infants totally blind from birth make up the longitudinal intervention study (Fraiberg, Smith, and Adelson, 1969). Of these ten, five would have been considered "at risk" even if they had not been blind due to such factors as extreme poverty, unemployment, and mental illness in their families. These ten blind infants who received home intervention before one year of age all reached the normal human-object relations expected at eighteen months of age. Their performance on the Norris Scale placed them in the upper half of a blind child population. All are educable.

Hearing-Impaired Children

Horton (1978) addressed the importance of early intervention with some form of amplification for hearing-impaired children. Horton cited research data by Liff (1973). Liff studied the spoken language of three groups of second-grade children. The experimental group consisted of six hearing-impaired children for whom parent intervention and amplification had been provided before age three. These children were enrolled in a regular second grade class with the support services of a resource teacher. The second group consisted of five hearing-impaired children for whom parent intervention and amplification had not been provided until after age three. These children were in self-contained special classes, "their level of language being inadequate for integration in the regular class" (Horton, 1978, page 376). The third group consisted of six second-grade hearing children judged to be of normal IQ by their teacher. Results revealed that the first and third group were similar in language competence. Significant differences occurred in almost all comparisons between the late intervention group and either the early intervention group or the normal hearing group.

Mixed Handicapped Populations

The national Handicapped Children's Early Education Program (HCEEP) of the mid-1970s followed the development of 9,600 biologically impaired children representing a wide diversity and degree of handicapping conditions. All of these children had been enrolled in HCEEP programs. The report cites more accurate diagnosis of handicapping conditions because of early longitudinal observations. The greatest gains were in the area of personal-social skills, the least in motor development. Home-based services had better results. Two-thirds of the children moved into regular school classes where their cognitive development and social development were teacher-rated as advanced over children with similar handicapping conditions who had not attended preschool programs.

COST EFFECTIVENESS

Analysis of the initial costs of early childhood intervention shows that initial costs are often high. However, the long-term payoffs in terms of reduction of both human suffering and long-term remediation costs justify the initial investment as shown by several studies beginning with Skeels (1966).

Skeels (1966) described an experimental group of 13 children who had spent a total of 72 years five months in residential institutions at a total cost to the state of $30,716; the 12 contrast children had spent a total of 273 years in residence at a total cost of $138,571.

In describing the Ypsilanti Perry Preschool Project, Weber, Foster, and Weikart (1978) reported that this preschool program significantly reduced the need for costly special services.

In a paper presented in 1980, Weikart described the following savings that could be attributed to early intervention:

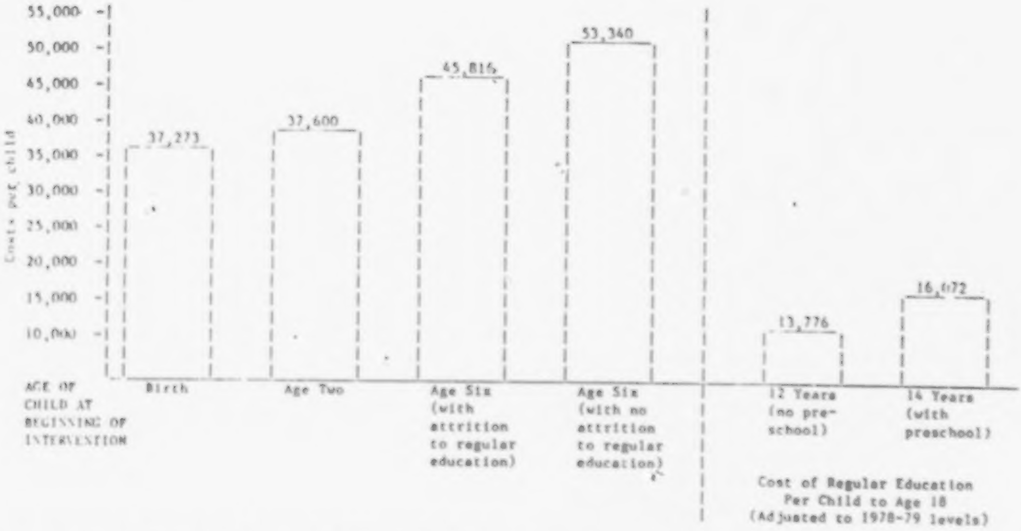
> The cost of two years of preschool for one child in 1979 dollars was $5,984. The total economic benefits were calculated to be $14,819, a 248 percent return on the original investment. These economic benefits came from three sources:
>
> 1. Lowered costs for education—less special education services needed
> 2. Increases in lifetime projected earnings
> 3. Values of mother's time released when the child attended preschool—$668 per child

Mary E. Wood (1981) analyzed single studies throughout the U.S. to obtain estimates of the average costs and cost savings of early intervention programs. She found that the costs of education for handicapped children increase as intervention is delayed. The earlier intervention is begun, the greater the savings. There are substantial savings to taxpayers when children receive intervention *at least by age two*, and *maximum* savings occur when intervention begins at birth. Figures 1 and 2 graphically show the cost of special education when intervention is begun at birth, two, and six years of age.

The Comptroller General's Report (1979) stated:

> The costs of preventable infant mortality, mental retardation, physical handicaps, child abuse, emotional handicaps, and lost human potential cannot be measured in dollars. . . . We believe effective early childhood and family development programs can reduce these problems. (page 79)

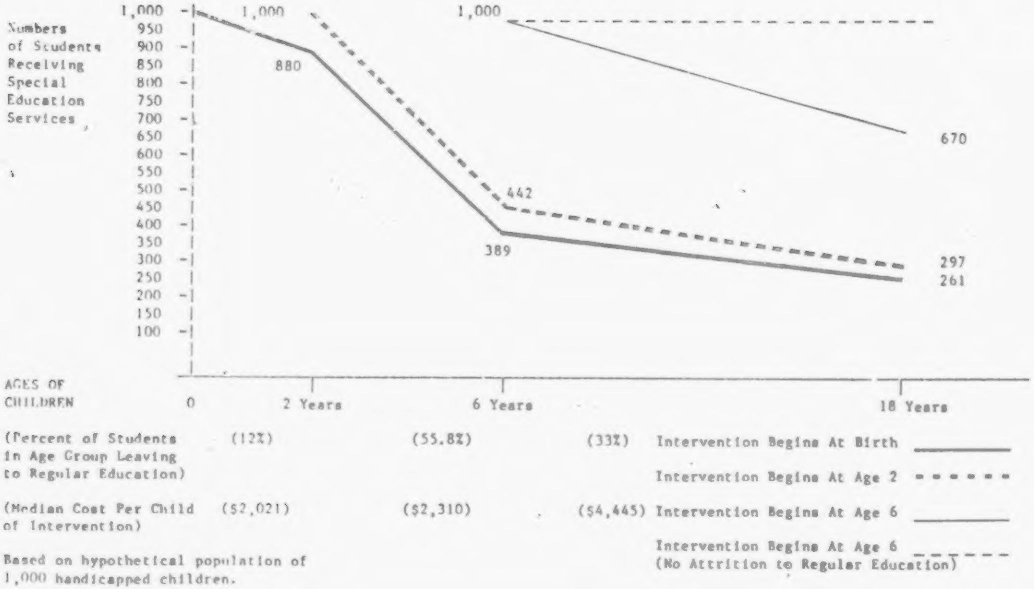
In summary, the human, ethical, and economic benefits of early intervention indicate the wisdom of providing services for young handicapped children to help them to become functional and productive members of society.



(Based on study of 960 multiply handicapped children, ranging from severely to mildly mentally retarded)

From Early Intervention for Children with Special Needs and Their Families: Findings and Recommendations. Edited by C. Garland and others. Monmouth, Oreg.: Western States Technical Assistance Resource (WESTAR), 1981.

Figure 1. Total Special Education Costs Per Child to Age 18
(Adjusted to 1978-79 levels)



From Early Intervention for Children with Special Needs and Their Families: Findings and Recommendations. Edited by C. Garland and others. Monmouth, Oreg.: Western States Technical Assistance Resource (WESTAR), 1981.

Figure 2. Comparison of Costs of Special Education as Intervention Is Delayed

SUMMARY--FACT SHEET

THE EFFICACY OF EARLY INTERVENTION

1. "Fifty percent (50%) of a child's intelligence develops before age 4, eighty percent (80%) of intelligence develops before age 8." (Bloom, 1964)

2. "If intellectual development is 80% formed between birth and age 8, the handicapped child will need the most assistance during the early years to develop intellectual abilities which lead to a satisfying life." (Hammer, 1972)

3. "Research has shown that there may be critical periods for the development of certain skills, and that most of these periods occur in the first three years of life." (Hayden and McGinness, 1977)

4. "With a delay in remediation of an intellectual or cognitive handicap there is a cumulative achievement decrement. . . . Apart from the danger of secondary emotional or sensory handicaps, the condition is progressive--the child's developmental status inevitably becomes worse with respect to other children as he grows older." (Jensen, 1969)

5. Skeels and Dye (1939) took two groups of orphaned institutionalized mentally retarded infants as experimental/controlled groups. The experimental group was given an enriched environment; the control group was left in the ward with little stimulation. By 1942 the experimental group gained an average of 27.5 IQ points; the control group lost an average of 26.5 IQ points. Follow-up studies in 1966 showed these results:

Control Group	Experimental Group
Four still institutionalized	All self-supporting
One dead after long period in institution	Median grade completed--12th
Average grade completed--less than third	Average time in institution--5 years
Average time in institution--22.75 years	More satisfying life in all aspects measured

6. Kirk (1958) chose 81 children, ages three to eight years; IQ range 45-80. The experimental group received nursery school training; control group--no nursery school. Follow-up covered several years.

   Results: 70 percent of experimental group gained 10-30 points in IQ. Control group IQs declined.

   NOTE: No studies which involved children six years or older were able to equal the gains of Kirk and Skeels.

7. "Intervention with deaf youngsters before the age of two resulted in these children's adaptations to normal classrooms whereas deaf children who were not in intervention programs until the age of three did not make these adaptations." (Horton, 1978)

8. "Blind babies must have tactile and auditory stimulation during the first year of life to avoid maladaptive and stereotypic behaviors." (Fraiberg, 1977)

9. Down's infants enrolled in early intervention programs reached developmental milestones at or near ages for normal children, while Down's children not in programs were delayed from 10 to 40 months on the same milestones. (Hanson, 1978)

Studies of Disadvantaged Children

1. Heber and Garber (1975) studied 40 infants with deprived mothers who had IQs of 75 or less. Twenty infants were given day care to age five. Twenty infants were left at home.

   Results: Major differences in IQ appeared at eighteen months and continued to six years.

   Follow-up studies in 1978 showed the following:

   IQ: Experimental group average 100; Control group average 80.

2. "In programs of early intervention, children showed substantial gains in IQ and other cognitive measures during the first year of the program, attaining the average or even exceeding the average for their age." (Bronfenbrenner, 1975)

3. In 1978, Lazar and others described an 18-year longitudinal study of 14 yearly intervention programs for disadvantaged children and reported the following:

   IQs increased and the increases faded by end of the third grade, but gains reappeared at the seventh and eighth grades. Special education placement and retention decreased for the experimental group.

4. "Only 1% of children whose parents had participated in a home-based program needed special education in 5th grade compared to 30% of control group who needed special help in 5th grade." (John Meier--Office of Child Development)

Cost Effectiveness

1. Skeel's follow-up study in 1966 showed the following costs for his experimental and control groups:

Experimental Group		Control Group
$4,800	Average income	$1,200
72 years	Total years in institution	273 years
$30,716.01	Total cost of institutionalization	$138,571.68

2. E. D. Fredericks (1980): 94 of the 131 children in Oregon who transferred from segregated TMR (trainable mentally retarded) classes to less costly integrated settings or resource centers had attended preschool.

3. Horton, 1978: The average cost per capita (in 1973) at the state school for the deaf was $5,106. The average per capita cost in a regular classroom was $847. The infant intervention program cost was $1,710 per year. Early intervention, which permitted hearing-impaired children to move into regular classrooms, resulted in considerable savings in actual educational costs.

4. Comptroller General's Report (1979): "The costs of preventable infant mortality, mental retardation, physical handicaps, child abuse, emotional handicaps, and lost human potential cannot be measured in dollars. They are only observable in human suffering, both in the parents and the victimized children. We believe effective early childhood and family development programs can reduce these programs."

5. The President's Commission on Mental Health Task Panel on Prevention, February 15, 1979, states ". . . that major primary prevention efforts must be focused on prenatal, perinatal, infancy, and childhood periods. . . . Top priority for program development, training, and research in primary prevention should be directed towards infants and young children and their environments, including particularly efforts to reduce sources of stress and incapacity and to increase competence and coping of the young."

6. President Reagan, when identifying special programs whose 1982 budget would not be cut, identified Head Start with 10% handicapped enrollment as a program which makes "taxpayers of potential tax eaters."

The evidence for the cost benefits of intervention is compelling. The cost of long-term remedial treatment and special care for handicapped school-age children and adults is far greater than the cost of early intervention which frequently makes productive citizens of children who would otherwise go through life dependent on others.

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CHAPTER TWO

COLORADO RESEARCH DESIGN STUDY

Four Colorado School districts — Adams County, Boulder Valley, St. Vrain, Weld County — provided preschool special education for children from 1974 to 1977. These districts participated in a program of scientific study to determine the effectiveness of preschool special education. One goal of the program was to improve language, thinking and social skills of three to five year-old handicapped children. Another program goal was to prevent future handicapping conditions for "at risk" children who might be identified as handicapped after they entered the public schools. For many children, the achievement of theses goals would:

- reduce later school problems
- reduce the need for special education services
- eliminate the need for special education services

INREAL (INclass REActive Language), developed by Rita S. Weiss, Ph.D. at the University of Colorado, was the special education preschool program used in these four districts. The INREAL program is a naturalistic, non-stigmatizing method of early childhood special education. This method is carried out within the classroom and emphasizes language development. Other studies have shown that language is the cornerstone of the learning tower which produces success in school.

Study Questions

The Colorado research design study asked three questions about the effectiveness of preschool special education:

1) Did the handicapped children who received preschool special education do better on tests than handicapped children who received no preschool special education?

2) If the handicapped children who received preschool special education learned more than the handicapped children who received no preschool special education, did this improvement last?

3) Does the long-term improvement in the handicapped children save money for school district special education programs?

Methodology

In each district, two equal groups of children were selected from the classrooms. One group of children received preschool special education. The other group received no preschool special education. The total number of children in the study was 518.

After the children finished the preschool special education program and went into elementary schools, their need for special education was followed for three more years (1977-80). Then, the cost of special education was calculated for these three years.

Results

For Question 1: The study results show that the children who received preschool special education scored statistically significantly higher on tests than the children who received no preschool special education.

For Question 2: The study results show that the improved learning in children receiving preschool special education lasts over time. The children who had received preschool special education needed significantly fewer special education services than the children who had received no preschool special education for each of the three years studied. These results demonstrate that the goals of the study, to improve learning skills in handicapped children, and to prevent handicapping conditions in other children, were achieved.

For Question 3: The study results show that the improvement in both the handicapped and the at risk children saves money for the school district, Even after subtracting the costs of the preschool special education program.

Copied from "Effectiveness of Early Special Education for Handicapped Children," A Report Commissioned by the Colorado General Assembly, 1982 the school districts over three years, saved $1360.00 per handicapped pupil and $1050.00 per at-risk pupil. Preventing later learning and school problems and reducing the need for special education services during the elementary years saves Colorado' tax-payers money.

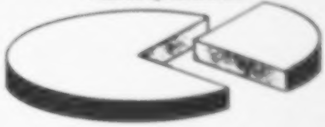
Data

Two separate groups of children were examined. One group included children who were identified handicapped as preschoolers. The other group included children who were not identified as handicapped during their preschool years but who were "at risk" (due to medical or environmental conditions) of being identified as handicapped when they entered school.

Group 1 - The follow-up study results for the children identified as handicapped showed:

During 1977-78

- 29% of the children who received preschool special education needed no further special education services.



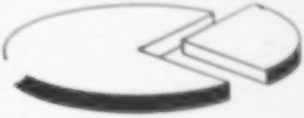
Preschool Special Education

- all of the handicapped children who received no preschool special education required special education services.

No Preschool Special Education

During 1978-79

- 19% of the handicapped children who received preschool special education needed no further special education.



Preschool Special Education

- all of the handicapped children who received no preschool special education required special education services.

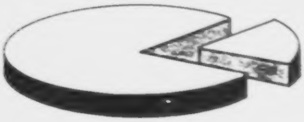
No Preschool Special Education

Even though some of the children who had received preschool special education continued to need special educatoin during the elementary grades, by the third year 38% no longer needed special education. On the other hand, only 7% of the handicapped children who received no preschool education no longer needed special education services.

During 1979-80

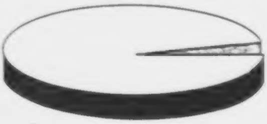
- 38% of the handicapped children who received preschool special education needed no further special education.

Preschool Special Education



- 93% of the handicapped children who received no preschool special education continued to require special education services.

No Preschool Special Education

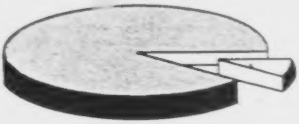


Group 2 · The follow-up study results for those children at-risk of being identified as handicapped after they entered public school showed:

During 1977-78

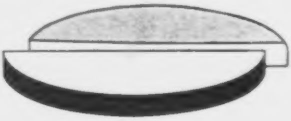
- 85% of the children who had received preschool special education needed no further special education services.

Preschool Special Education



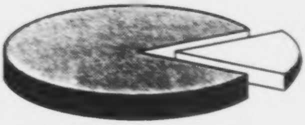
- 51% of the children who received no preschool special education were identified as needing special education services.

No Preschool Special Education



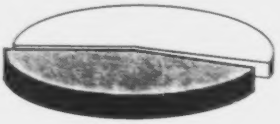
During 1978-79

- 84% of the children who had received preschool special education needed no further special education services.



Preschool Special Education

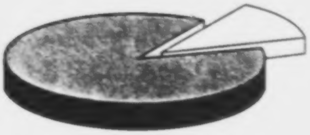
- 62% of the children who received no preschool special education were identified as needing special education services.



No Preschool Education

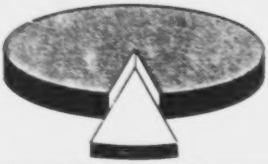
During 1979-80

- 89% of the children who had received preschool special education needed no further special education services.



Preschool Special Education

- 38% of the children who received no preschool special education were identified as needing special education services.



No Preschool Education

RESULTS

The results of the experimental research design study show that the goals of the program were met. Handicapped children who attended a preschool program when compared to handicapped peers who did not:

- did significantly better in school over an extended period of time
- had a reduced need for special education services
- were more frequently able to benefit from regular education without any special support.

In meeting these goals the INREAL program demonstrated that handicapped children will achieve more success in school as a result of having a preschool experience. Besides the human benefit there is also an economic benefit gained in the reduced or eliminated need for expensive special services later on in a child's educational career.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH
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(617) 727-5090

To: Martha Zeigler

From: Karl Kastorf

Re: Early Intervention component of 94-142 reauthorization.

Date: July 16, 1986

This is the information that you have requested regarding the early intervention part of Senate 2294. I have divided my comments into sections.

COST; INTENDED BENEFICIARIES

In state fiscal year '86 the per child cost of providing early intervention in Massachusetts was $2,500 per child. On the average this provided a child and his family with about 7 hours per week of service which included about 40% home visit time, 40% center based individual therapeutic service, and 15% family or child group service. 5% was devoted to screening and assessment. Transportation is included in the cost. The home visit and center based individual service is provided 1:1 staff/child or staff/parent; group is about 1:4. With the exception of aides in the group, all service is provided by degreed professionals including OT,PT, Speech, Social Work and Education I won't detail how we arrive at the $2,500 figure; suffice it to say that we can substantiate this. It is not a guess.

Total program cost will depend upon scope of eligibility. The proposed legislation clearly includes those children that we would describe as being at established risk. These are children who have an established diagnosis or who are exhibiting very substantial delay in several areas. Our own needs assessments and work done by Sappenfield and others indicates that about 6.5% of all children ages birth to three fall into this category. This year in Massachusetts that is about 13,570 children. The cost of serving them is 2,500 x 13,570 or $33,925,000.

Assuming that state effort is maintained and that, as the bill suggests, Medicaid will participate, the Federal cost (including a potion of Medicaid) for service in Massachusetts at various levels of Federal participation will be as follows:

	FEDERAL PARTICIPATION (in millions)			
	40%	50%	80%	100%
DPH prevalence estimate - 13,925 infants 6.5%, 0-3 pop.	6.08	7.605	12.168	15.21

Including children "at risk" rapidly increases the number of children to be served. A second category of children are those at biological risk. These are children who have been exposed or have experience a biological insult that is known to create significant risk of disability. Such risks would include very low birthweight (below three pounds), lead ingestion, apnea at birth, parental substance abuse etc. These risks do not always cause disability so we have felt comfortable by defining the size of this population according to the size of the very low birth weight population that survives the first month of birth or .549% of children birth to three. In Mass. this group now includes 1200 children.

A third category is children at environmental risk. These, in theory, are children who exhibit no delay but who are living in an environment which is known to increase their chances of being delayed or disabled. Obviously, this definition creates controversy. To estimate prevalence we count children who have two of the following four factors:

children born to young teenage mothers (<18)
children born to older teenage mother (18 + 19) with a previous live birth.
children born to mothers with less than a high school education
low birthweight (not very low birthweight)

Through this method we find that 4.7% of the birth to three population is at environmental risk. Let me emphasize that we do not use this method to determine eligibility; it is only usefull for prevalence estimates. By this method we identify about 10,600 children.

The term "substantial developmental delay" appears to exclude children at biological and environmental risk and children who appear sound but for delay in one area (such as speech). However, we have seen time and again that it is these children who do not appear until first or second grade and then have major problems in adjusting to school or in learning. In the end these children receive 94-142 services. Broadening the definition to include ". . . and children at risk of substantial developmental delay" is simply good sense. The $2,500 per child cost probably does not apply to the child who does well with only 1 hour/week of motor development training or the very young mother who gains important parenting skills through only a weekly hour long home visit. These are low cost, effective preventive services.

EFFECTIVE DATE

Massachusetts has in place many of the elements of a comprehensive system, including a statewide advisory committee. However, we have a grave shortage of qualified staff, including PT's and OT's. Salaries are certainly a part of this problem but they are on the rise as demand increases. At present, universities in New England are not producing sufficient numbers of OT's, PT's, Nurses and educators with skills in early childhood development to meet my limited expansion needs. We simply could not staff a service system serving 13,000 children. However, as demand grows, so does the demand on the Universities and they are considering capacity expansion. We are working with them but we do need more lead time. Three years should give us a leg up on this problem. We must be allowed to use a substantial portion of Federal implementation phase funds for staff development (pre-service ed, continuing ed. etc.) Our turnover last year was 35%. If we can lower this by 5% per year in each of three years through salary growth and increased staff development we can stay abreast of the need.

Federal service funds (after three years) should be apportioned on the basis of numbers served.

GOVERNANCE

Some states, New Jersey and Maine among them, have done well by very young children through a service delivery system that works through coordination of services from several agencies. We seem to have done better using a Lead agency approach. States ought to have the option. However, states should be required to identify a single point of entry and a single source of case management services. The program should be operated at the state level.

PROCEDURAL SAFEGUARDS

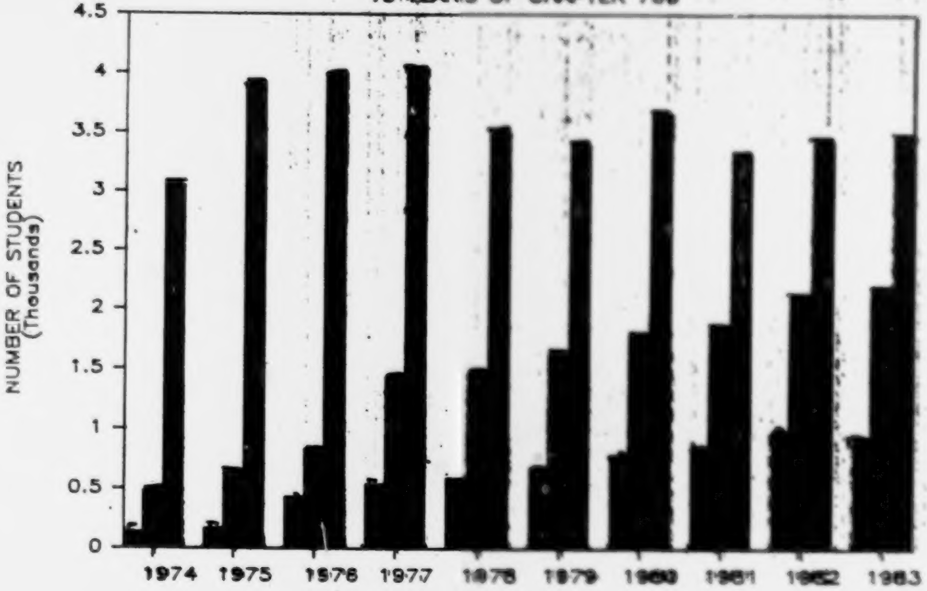
Parents of very young children tend not to assert their rights and often choose to assume that the service delivery system knows what it is doing. There ought to be some sort of independent, perhaps even third party system to work with parents in this system to assure that they are actually aware of their rights.

NATURE OF THE 0-3 MANDATE

The "work" of children 5-21 is learning; they do this in the mainstream of school. This gives an inherent focus and purpose to 94-142. The work of children birth to three is development; their mainstream is the family. Reflecting this in the legislation would clarify the purpose of this program and would help to avoid future confusion. The purpose of early intervention is to assist the child in achieving his/her maximum developmental potential. The nature of this program is, and has to be, family centered. Failing to specify this clearly could lead us up the blind alley of creating an an out-of-home care system that focuses only on adjustment.

3/4/5 YR OLDS IN SPECIAL EDUCATION

10 YEARS OF CHAPTER 766



Source:SSSR

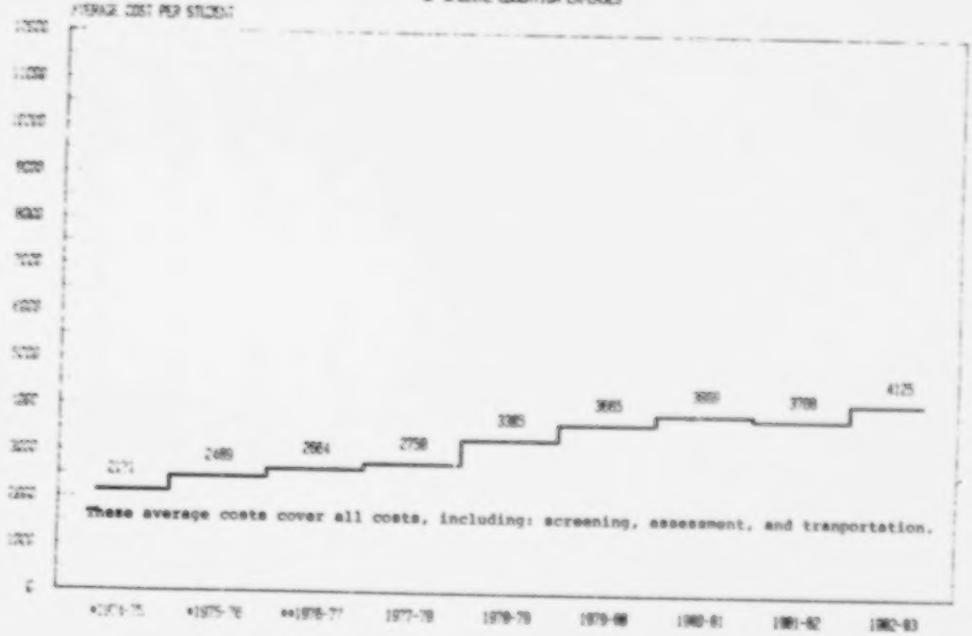
Col. 1 - 3 YR OLDS Col. 2 -4 YR OLDS Col. 3 - 5 YR OLDS

Massachusetts Department of Education

PROGRAM DISTRIBUTION

pc 4 # 2

OF SPECIAL EDUCATION EXPENSES



These average costs cover all costs, including: screening, assessment, and tranportation.

PROTOTYPE 502.8 **(Preschool Special Education Placement)**

Massachusetts Department of Education

Mr. **Hayes**. Thank you. Each of you presented interesting testimony. We do have a few questions that we want to raise with you.

The first question is directed toward you, Ms. Vaughn. In your prepared testimony, you state that the American Federation of Teachers supports Senate bill 2294 contingent on the law being made a Federal entitlement whereby the Federal Government would seriously undertake the responsibility to pay a fair share of the cost involved.

Now what, in your opinion, is a fair share?

Ms. **Vaughn**. Well, first of all, there is question about what the amount of the program would cost, and a fair share would certainly be a proportionate share that would go into the States who were required to fund these programs; and that would be based upon the numbers of students that would be identified to go into the program, the personnel that would be required to be included and hired to provide the services necessary, the facilities that would have to be provided, the equipment, staff development, the ongoing services that would be necessary.

All of that would be based on a fair assessment of what it would take to initiate that expanded program in the various States that currently provide those services, or that would be mandated to provide those services.

As you know, the whole profession of teaching is suffering a serious shortage of qualified, competent personnel who are regular students, and certainly to get people to come into teaching special education and the handicapped, the early childhood program has generated a new interest in higher education and teacher training institutions because, under the new reform movement, many States have enacted and put aside money to initiate early childhood programs, which we know have been very successful in that those children who are exposed to preschool and early childhood programs succeed much more effectively in the middle schools and higher education.

So we certainly hope that a serious assessment will be made based on those concerns that I have raised.

Mr. **Hayes**. I can understand the apprehension which your union is approaching this whole question of your support to your 2294 in principle.

Given the kind of problem that you are currently having, which I'm now somewhat knowledgeable with the State of Illinois where you—after having gotten commitments through contractual negotiations for salary increases for employees of the Board of Education. The last I read, there is some question as to whether or not the State is going to live up to its commitment.

Ms. **Vaughn**. In our particular——

Mr. **Hayes**. Some $50 million, I think, short fall, despite the kind of money we rake in through my contributions at least, some of it, on the lottery.

Ms. **Vaughn**. Well, we understand that, while they've made an effort to keep the level at the $50 million, that has been done at the expense of expanding and continuing programs that were in effect before. They would have a further excuse now to not implement or go forward with the early childhood program for the nonhandicapped aged 3 to 5, because now they're trying to find out how much it would cost to expand it through the special education program.

I have particular empathy, because I am a special education teacher. I know the value of having these opportunities extended to those children, because they, too, should be given the opportunity to develop at an early age. But I also am very cognizant of the problems we've had of finding adequate facilities for the present program that we have for special education students.

I am not concerned that we open again and expand and have our children be placed under stairwells or in little former teacher lounges because this is in fact what happens, because the school district has inadequate funds to open a position. Any facility that is adequate, that has the equipment and has a person who is qualified to teach the children—that's a very serious problem, and it can't be done overnight, and it does cost money. And yes, the salaries have to be attractive, because young people who are interested in education are not opting to go into it because it has been frought with so much controversy in the years about whether or not the salaries are competitive with private industry, whether or not you will have the kind of support from the community and the parents for the program.

We also know it's absolutely essential to have the degree of parent involvement in getting the program put into effect, and that the local school districts have to feel that they can use the dollars for those programs. We've had cutbacks in categorical aid, in program funding from national as well as the State level, and has been reduced for the existing program.

So we're very concerned that, if indeed this law is enacted, serious consideration be given to funding it at a more realistic level at both the State and the national level, and certainly within the local school district with all of the safeguards built in that my colleagues pointed out are necessary.

Mr. HAYES. You are saying this in sum total, that A.F.T. is supportive of the concept, but the funding must go along with it.

Ms. VAUGHN. We would think it should be an entitlement program.

Mr. HAYES. Even if it runs into the billion?

Ms. VAUGHN. Well, you know, nothing is cheap, and education is the first priority for all children, and I think that should be given serious consideration.

Mr. HAYES. Now I just have one more question. Then I'm going to call on my colleague Mr. Goodling.

Mr. Oglesby, in your testimony you said little about the early intervention program for the 0 to 2 population. I'd like to have your position with respect to this program.

Mr. OGLESBY. The early intervention program for the 0 to 2—The public school system is not set up to deliver the system for that. My testimony concentrated on the 3 to 5 year old primarily because that is the area in which we believe that the program can provide some assistance on the assumption that, again, as was stated, that it is fully funded.

The 0 to 2 category presents a significant number of problems for the public educational delivery system.

Mr. **Hayes**. What do you consider is adequate Federal funding for the 3 to 5 mandate?

Mr. **Oglesby**. We're considering fully funded, of course; because as we are looking at it, there is no way that we can continue to dilute the current resources that are available to provide improvements. Education has come under a lot of criticism lately, particularly after the "A Nation At Risk" came out, because all of a sudden no one believes that anything productive was going on in the public school system. As you know, efforts have been made to do a number of things to improve public education.

As those of us that are in policy making positions try to improve this image, try to improve the quality of the education, try to improve the quality of the profession, and to provide more resources for the staff that are working with those areas, get better qualified staff—as we approach those targets, we're running against—we're swimming upstream.

The resources that we are using to provide this at the State and local level is decreasing. We have problems with not getting tax levies passed. In some States, there are trigger mechanisms rolling back the property tax level. There are also State mandates that are not fully funded, and I'm just not sure how many more programs we can handle, not fully funding them, and continuing to stretch the existing resources there within the district.

This one provides some unique problems, because most States are set up to handle the school aged children. There are some insurance legalities that are there. There are some problems with our presumptions as to whether or not the system is designed and can handle the 0 to 2, and we really would like to continue to press for full funding of the 3 to 5 program.

94-142 is again down in terms of projections of the funds that are to go into it at the Federal level for this year, and it's still mandated.

Mr. **Hayes**. I know that you are conscious of the fact that we are swaggering under a deficit—Federal deficit that's going to reach the $300 billion proportions if it hasn't already reached that. Hence, the trend and the movement here within this House of Representatives has been to try to find ways to reduce the deficit by contracting programs, many of whom are social such as the one we're talking about here, rather than expanding them.

I don't necessarily say I agree with that, but I just want you to know that, when you say fully funded, take into account that Gramm-Rudman is here, some of the revenue sharing programs that we've had, particularly for cities, have been threatened with extinction.

So I don't want to be a prophet of gloom and doom, but I just want to be factual and accurate with you. Now I just want to say to Ms. Hart, I certainly admire you for the manner in which you've handled some of your personal experiences.

Lord knows, someone less determined might have found a basement window to leap out of, in some circumstances.

Ms. **Hart**. I'm not alone. I mean, if you get a group of parents together, they can tell you similar stories. The thing is, it's still going on. It's still sad to see that it's still going on. Regretting the whole financial thing, we now have figures that show that you save money in the long run. We can invest our money early and have fewer kids in special ed. We can have fewer delinquents. We have fewer drop-outs. We have all of these.

So it's not just something that is emotionally that I'm asking for. Economically, it makes sense.

Mr. **Hayes**. It might be well if you would pass some of those figures on and make it part of our record at least.

Mr. Goodling?

Mr. **Goodling**. Mr. Chairman, I don't really have any questions. I do have a few comments, which won't be appreciated by many, I suppose, but I think it's important that we be realistic. Having been an educator most of my life, I will take a back seat to no one in trying to make sure that there is equal opportunity for a good education for all youngsters. We have to be very realistic. I've been trying to tell the committee this year not to put legislation on the books and encourage people when we know very well that the legislation is not going to be funded. It seems to me the worst thing that we can do to a constituency is to kid them that something's going to be funded when we know very well it isn't.

I've been trying to find some way within the existing system to fund new legislation. It was mentioned about wanting an authorization attached. That's one of the problems we have, because an authorization means positively nothing. We can authorize, and we do all the time; but it's only the appropriation that matters.

I'm surprised that the Senate would push something through so rapidly with very little thought about it, even though it's an election year; because it just isn't going to be funded. It's as simple as that.

You understand the problem we have in relationship to our present programs in handicapped education. We promised when we passed that legislation that we were going to send 40 percent of the funds in order to finance it. The best we've ever done is gotten up into the 13 percent range; about 9 now. I just don't think it is good politics even in an election year to try to give somebody the hope that, by putting a program on the book, there's going to be an appropriation for that program.

I have real concerns about this bill. There's no one more interested in early childhood education than myself. I'd like to get $3-4 billion for the kind of education that I used to do in Chapter 1 money, but I'd like to do it for many more young people and their parents.

I think that we can do something about the 26 to 60 million functional illiterates we have in this country if we could fund a program like that. But I know, and I think all of you know, that we're not going to get that kind of appropriation for any program that we offer at this particular time.

During a Budget Committee meeting yesterday, CBO reported to us, as a matter of fact, we're back up to a $220 billion deficit probably in 1986 even after our sequestration in March, for many reasons. First of all, there is a slowdown in the economy and low inflation which means all those automatic pay increases don't take place and, therefore, automatic increased tax doesn't come. In addition, as Americans, we seem to like to buy what is produced in other countries much more than we do here.

What you are asking us to do is what I would like to do for all children. I'm not a Constitutional lawyer, but I have to believe the minute you put on the books a mandate for one segment of our society in relationship to 3 and 4 year olds, I don't believe you can deny that mandate to any other 3 and 4 year olds.

Keep in mind, in Head Start that's a voluntary thing. In my district, there's probably only one city that has Head Start. Not any other area, and in my district there are a lot of school districts that don't even have kindergarten. Now we at the Federal level would mandate, as a matter of fact, you not only have to institute kindergarten but you're going to institute programs for 3 and 4 year olds. I believe, constitutionally, all 3 and 4 year olds, if you move in that direction.

I'd like to see that program, if you can find a way to fund that program; but we have to be very realistic.

Developmentally delayed—What does that mean? My wife is a first grade teacher. Every child who doesn't have a reading readiness skill to begin to learn to read when they arrive in the first grade classroom, in my estimation, are developmentally delayed. That could be an awful lot of students we're talking about. How do you determine those students in relationship to that 3 and 4 year old program?

The concept is good. It's something I'd like to do for all 3 and 4 year olds. Not mandate for all 3 and 4 year olds, but in many instances certainly 3 and 4 year olds probably are doing better not in a mandated setting. But I'd like the opportunity there for them.

I do want you to understand that we have to be realistic. We can authorize and build up your hopes until there's appropriation. Nothing happens. We have a lot of programs that have never been appropriated. We're initiating programs now, this year, that won't get appropriated; but we're building up hopes back there with our constituents because we've authorized them.

I like your concept. It's something that has to be done. It has to be done for all 3 and 4 year olds. I don't want to encourage you in any way, shape or form that there will be some kind of appropriation in order to handle it. It seems to me we're wrong time and time again at the Federal level mandating what must be done at the State and local level without then also coughing up the money to help them with that mandate, and that's what we've done with handicapped education.

I don't want you to go away here with great hope that if this goes through the House, that somehow or other there's going to be an appropriation. I just don't believe that there will be appropriations for very many new programs, and I truly believe that we are mandating. If we mandate for 3 and 5 year olds who are developmentally delayed and handicapped in any way, we positively must offer the same to all 3 and 5 year olds.

Think of the impact in districts. You've heard some people who say in many States people get an opportunity to vote, and oftentimes the very people who are clamoring for more expenditures are the very people who go to the polls then and vote against any increased expenditures. You heard about all those Proposition 13's, 10's, three and a half's, 12's and what-have-you.

I know a district that started cutting out music and sports and so on in order to try to cope with it and said, that isn't what we meant. So I just want you to go away understanding the realistic side. Even though I am emotionally with you and, from an educational standpoint, with you, reality says there will be no appropriation. I want you to understand that.

Thank you, Mr. Chairman.

Mr. **Williams**. Thank you. Mr. Bartlett.

Mr. **Bartlett**. Thank you, Mr. Chairman.

To the witnesses, I've reviewed your testimony, and I do very sincerely and personally apologize for not having been here earlier in the hearing. We had a committee markup of a full committee at the Education and Labor going on at the same time, and simultaneously a conference report on the Handicapped Children's Protection Act on the House floor. So I never learned how to be in two places at once, and today I had to try to learn how to be in 3 places at once. I missed one.

I want to confirm some of the testimony that I have read. First, Ms. Vaughn, representing the American Federation of Teachers, in your testimony you say that the American Federation of Teachers offers support for Senate bill 2294 contingent upon the law being made a Federal entitlement.

You know, I really want to understand. Does that mean that you oppose, or the A.F.T. then opposes the bill, since the bill does not provide—as Mr. Goodling said, it's unlikely to see a Federal entitlement. So, therefore, you would—or your organization would oppose the legislation?

Ms. **Vaughn**. Well, I think Mr. Goodling's comment illustrates our concerns and our reservation for this legislation. Inasmuch as the Federal government has been unable to fulfill the mandate in terms of funding to the level for 94-142, and here we're proposing an amendment to further exacerbate the situation. So we're saying what has been said earlier, that if such a mandate is put on, there are many, many concerns and many, many issues that have to be taken into consideration to determine the total cost of any such program, including personnel, the facilities, the equipment, the staff development, the recruitment, the child find and numbers of students who would be served, and the States where it is mandated, those that are not. It's a very serious undertaking if it is not funded to the level that would be realistic.

Mr. **Bartlett**. Do you have any sense as to the total cost? Has A.F.T. done any kind of analysis of the total cost that this change will cost?

Mr. **Vaughn**. They have—This came on very quickly, as you know, and I don't think that we have a dollar figure on the amount. I think my colleague from the school board association gave—I am told there would be approximately $2.7-$3 billion, based on estimates that have been made for just the 3 to 5 year olds. I think that's a very large amount of money to add to the deficit, especially when the basic education programs are having difficulty.

Mr. **Bartlett**. That does point out one of the difficulties that this committee has with the fast track, and that is, that we still don't have quite the basic information. I hope that we get it, because I think that early intervention is a good cost-effective concept that saves tax money in the long run. But, nevertheless, the official estimates range from between $180 million and $2.7 billion, it does seem to me that we ought to be very careful about passing legislation until we can all at least agree on what the population is and what the total cost of the——

Ms. **Vaughn**. That's our basic position.

Mr. **Bartlett**. So the A.F.T. then——

Ms. **Vaughn**. We support the concept and we fully support the idea that a free public school education should be provided for those young people who are able to take advantage——

Mr. **Bartlett**. Ms. Vaughn, it's okay to say you oppose legislation if you oppose legislation. I do it all the time.

Mr. **Hayes**. Will you pull the mike up so you can be heard.

Ms. **Vaughn**. I don't oppose the legislation. I oppose the initiation of programs that are not funded, and I think that those persons who come up with the idea should be cognizant of the impact of that on existing programs and certainly on the hopes and aspirations of those children who do not now have an opportunity to get those programs.

Mr. **Bartlett**. Okay. The U.C.P.A. testified—Dr. Hart—as I understand, you support the legislation, but you have several changes that you would urge that we make. Is that basically correct?

Ms. **Hart**. The changes are not big changes. They're more to ensure that the program is carried out effectively to serve the children most adequately.

Mr. **Bartlett**. So the United Cerebral Palsy organization is generally supportive of the legislation as it now stands, but would offer some improvements to it?

Ms. **Hart**. Very much so.

Mr. **Bartlett**. My question: One of your improvements—I want you to expand on it a little bit—is in the area of definition of an infant with a handicap. Is it your general sense that we ought to narrow the definition from what is currently in the Senate bill to be more consistent with what is in, for example, 94-142? Or, how would you have us approach the definition?

I think the way we arrive at the definition will have a lot to do with what the ultimate costs are, because that will then define the population. So how would you approach the definition?

Ms. **Hart**. It's defined in 94-142. I think it's too limiting for children who are below school age. I don't think that you can categorically define. In the testimony, I showed that my son had had so many, my grandson has had so many, labels attached; and I think too often children are excluded from service because of those labels, or because it takes so long to get the label attached that the children lose services in the meantime.

They're sitting, or they're in another placement where they're not getting adequate services, waiting for the labeling to go through.

As far as the infants are concerned, I work with these babies. We assess these babies every week, and you can see infants who come in who are definitely in need of services. They are very, very handicapped. But there are also infants who come in whose mothers are drug addicted or disturbed or retarded or whatever.

We watch those infants go downhill literally. We can test and evaluate them at 6 weeks of age, and they are functioning as normal infants. Therefore, if we have to wait until a child is labeled retarded and in an area, we can't serve them. But those same infants we see by the time they're 6 months old, they start going downhill. I live in a State without mandated or permissive preschool education. By the time the children are 3, when they can avail themselves of Head Start programs, they are retarded. They are disturbed. They are—whatever. In other words, we could have done something early on to help the mothers with those children, to intervene. It would have been very inexpensive at that time. But by waiting until they're eligible for other programs, the children's behavior has disintegrated. The home situation is atrocious. The children end up being removed from homes, put in child service custodies, all of these kinds of things.

So I think too narrow a definition is also a disadvantage.

Mr. BARTLETT. Would you be inclined to—Let me try to pursue that just a little bit. If the home has a bad environment, you're not suggesting, or perhaps you are, that that necessarily would mean that the child would be covered?

Ms. HART. No. One of the things that we're playing around with in Pennsylvania right now is the term potential of being handicapped, and that has to be documented in terms of what the potential is. We know from different studies that the impact of a mother is so great on a child. The mother who is disturbed has a tremendous influence on her child, a mother who is retarded. So those would be the targeted families.

Mr. BARTLETT. One last question, with the Chairman's indulgence, that I would ask to each of the witnesses, but particularly the U.C.P. and the School Boards. That is this—and let's focus on the birth through 2 portion of the—which is a different portion of the bill, and I think it is a different concept as far as consideration between the 3-to-5 mandate.

In a perfect world, if you could tell us whether, in your opinion, if you could simply choose whether to make services for birth through 2 as an educational service through the school districts, or more of a health and other kinds of service through other lead agencies, which would you choose?

Now the bill allows the Governor to make that choice of the lead agency. One of the difficult things about birth through 2 in this bill, though, is that the way human nature works, is if we put it in an education bill, that generally would drive governors toward thinking of it as an educational function.

So without relation to this legislation, in your judgement, would those children birth through two be better off served as an education function or as a health or social service function?

Ms. HART. It has been my experience, most schools are not equipped to handle the birth to 2. It's a group that needs not just teachers, but they need physical therapists, occupational therapists, good social work in the home. They're best served in the home where the parents can learn to handle them right within the routine of normal child care.

Most school systems don't understand flexible time when the families are served on the weekends, where a mother and dad are both there. They want regular school hours. They're not used to having all of these team members come in and get together and assess in the way that you have to assess an infant.

So they're just merely not set up for that. I'm not saying that they couldn't be, but at the present time I think most States themselves would opt for a—what?—a flexibility also in who would take this permanent——

Mr. **Bartlett**. If you could choose, you would choose a non-educational as the lead agency?

Ms. **Hart**. I think at the present time, until we become much more into it.

Mr. **Oglesby**. In my testimony, I indicated that the school systems are not designed to handle the 0 to 2. The system itself—I work for a university and a college of education as a faculty member. There is no training available in the colleges for the professionals in that particular area.

The staff development is not there. In my testimony, I pointed out that some other agency other than the school system should be designated as the lead agency in this.

Mr. **Bartlett**. Ms. Ziegler?

Ms. **Ziegler**. Well, in my testimony, I indicated that parent leaders around the country could not reach agreement on that particular point. I would say on that basis that we probably would support the flexibility in the bill that allows each State to make a selection, but we certainly agree with Dr. Hart that families and babies in those early years need services that are not usually supplied through education.

Mr. **Bartlett**. Ms. Vaughn?

Ms. **Vaughn**. My testimony was directed toward the age 3 to 5 year old, simply by virtue of the fact that they do not presently have provisions in the public school system that we are representing for 0 to 2; and I don't think it's realistic to think that we would be able to implement a program at this time, given the structure.

Mr. **Bartlett**. Thank you, Mr. Chairman.

Mr. **Williams**. Thank you. I, too, want to apologize for missing the testimony of two of you, but Ms. Ziegler and Mr. Oglesby, I'll read your testimony. We appreciate your being here.

I was on the floor managing the Handicapped Children's Protection Act, the attorney fees bill. So it was a matter which I know is important to you, as well as to this committee.

Let me say to you what I said yesterday when we opened these hearings, and that is, that I'm a believer personally in early intervention, both from a humanitarian as well as an economic standpoint, and my colleagues are correct. We have economic troubles larger than we thought even, according to some information those of us on the Budget Committee received yesterday.

So it is important that we find ways to invest money in order to save it in later years, later decades. Intervention for the disabled, it seems to me, is one of the ways to do that. So the question is not, should we do it; but the question is—and that's what these hearings are about—how should we do it, and when should we do it?

You're a great help to us in trying to determine that.

With regard to economic considerations, let me take my hat off as Chairman of this committee, put on my Budget committee hat and just say to you that it may be that the deficit which is growing faster than we had anticipated and much faster than the White House had anticipated earlier this year might restrict us from making this an entitlement. But if it does, it will have wrongly restricted us.

This hearing today has now run about two hours. Yesterday we were here 3 hours. If we had started the Pentagon spending clock ticking yesterday when we started the hearing, we would find that by now the Pentagon has already spent more money while we've been hearing this legislation than this legislation calls for through the appropriations process.

So it depends where this Nation wants to spend its vast resources. They may not be as vast as we thought, but with the Pentagon spending more money than is in this bill during the 4 hours we're just hearing whether or not we ought to spend the money in this bill, it's very clear that we simply ought to get our priorities right, reset the Nation's compass, and move on to do the kinds of things that we ought to do in this country.

So, as Chairman, I'm for that.

Now let me ask Professor Vaughn a question with regard to the effective date of this legislation. As you know, it's a three year effective date. There has been concern expressed that we do not have the personnel now in place, particularly, of course, teachers, to provide the educational services that are necessary for these young people.

I don't know whether you agree with that or not, but taking that into consideration also, is the 3 year effective date about right, not long enough, or too long?

Dr. **Hart**. I think, 2 to 3 years. There are State planning grants. Every State is using it. The stories you get from the people in the training—who are doing the training grants in some States are actually dragging their feet over the 5 year training grant period of time, because of the—their jobs. A lot of the planning and so forth—Well, sure, we could do it earlier, but this is the plan we've got, and it will be implemented over the 5 years. I think 3 years is very realistic.

I think some States could do it beforehand. As for the training, I think that there are—You know, you have training grants that are provided by the Office of Special Education. That money has been out there for a few years now training teachers for the purpose of early intervention, and I have a couple of training grants where we're training teachers to deal with babies from birth to 2. We're also training to deal with handicapped infants from 3 to 5.

So there are some places that are training teachers across the country. If you mandate this, there are not going to be enough teachers that are well prepared, but I think the same thing goes as when we went into 94-142. There needs to be a strong intensive inservice training component to get teachers to know that there is a difference between 3 to 5, in birth to 2 and the elementary aged child.

Mr. **Williams**. Ms. Vaughn—I think I called you Professor Vaughn, didn't I? I wanted to ask you both about the same question. So, Professor Hart, I apologize for calling you Professor Vaughn. Ms. Vaughn, I don't apologize to you, because I am going to call you by your correct name. Are you satisfied that in the Chicago system there is adequate personnel, particularly teachers, to make the applications necessary to provide the services to these children?

Ms. **Vaughn**. Certainly not. That's one of our major concerns, that there are not adequate personnel available who are qualified and competent to implement the program if indeed this were mandated and expanded.

We are just trying to find sufficient personnel to implement the new 3 to 5 year old program that was effectuated through the education reform movements in the State of Illinois. We do not now have those persons available.

I said in earlier testimony that we are having a problem recruiting teachers to the profession in the regular grades, and certainly to special education, for all the reasons we stated, the inadequate funding, the lack of incentives to come into the program.

So I think that the 3 year time period is realistic in those districts where you currently have a program for the non-handicapped, if the funding level is such that it can be done and put into place within that time frame.

Mr. **Williams**. Well, our thanks to each of you for being with us today. Your testimony has been very helpful, and we appreciate your taking the time to prepare it and present it to us.

Mr. **Williams**. I'll ask our second panel to come forward: Joseph Helmick, John Watts, Ann Bardwell, Carmen Taylor.

The rules of the committee say that we need a chair per witness, and so can we get another chair for one of those young ladies there. They're sitting together. Shouldn't they have their own chair? There you go, sweetheart. Sit down there.

We don't do that with every witness, but the important ones we need to——

Mr. Joseph Helmick is the Chairman of the Department of Speech Communications at Texas Christian University in Ft. Worth, and he's here representing the American Speech-Language-Hearing Association.

Mr. Helmick, we're pleased you're with us. Please proceed.

TESTIMONY OF JOSEPH HELMICK, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Mr. **Helmick**. Thank you, Mr. Chairman. It's a pleasure for me to be here not only to represent the American Speech-Language-Hearing Association but also in my capacity as President of the 2500 member Texas Speech-Language-Hearing Association.

I've been a certified speech-language pathologist for about 25 years, practicing in a variety of environments, including the public school context.

We are, as an association and profession, very much supportive of the concept being offered in this particular legislation, and I have submitted previously rather extensive testimony in written form which I don't intend to read to this committee at this time;

but there are some issues in that testimony that I would like to comment on in oral form.

Let me begin first of all by indicating that in the definition, we feel that it's important to include the notion that there are children who are medically and/or biologically at risk for developmental disability. If we intend to in fact propose that this kind of legislation will be as impactful in terms of early intervention, it would seem important that that kind of terminology find its way in some final writing of this legislation.

We also offer the recommendation that the funding pattern that is implemented be on the last dollar concept. We're particularly aware in Texas, for example, that there are existing agencies that are now providing early intervention services. It's our position that it would be counterproductive to provide any kind of disincentive to those agencies; that is, to allow a particular unit within the State to assume some of the responsibilities that are currently available. So we would like to encourage the last dollar concept in whatever funding declarations are listed in this particular piece of legislation.

We also are concerned that there are some statements in the proposed legislation that are not entirely clear. For example, the legislation proposes that there be access to these services at no cost, and yet does interject the notion that parents may be required to pay on a sliding fee scale for those services for which fees are available. This may be an issue that should require some clarification.

I think it's also not entirely clear as to what range of services will be specifically supported through whatever funding levels are advocated. Again, we have submitted testimony relative to the particular sections which that recommendation addresses.

We support the notion that the authorization involved here be one that provides for some continuity and continuation of the intent of this legislation, and that particularly at the State level where there may be multiple agency involvement, that some sort of interagency coordination be effected.

The thrust of our intent this morning, however, is on an issue that we consider to be fundamental to the entire legislation, and that's the notion of the qualified provider.

I think it's very difficult to talk in any forum about appropriate education if we do not also specifically address the issue of who is qualified to provide educational services or other related services.

In testimony before this subcommittee yesterday, it's my understanding that the N.E.A. did enter the definition that the American Speech-Language-Hearing Association has proposed in its written testimony. That definition basically asks that individuals who provide the services under this legislation be qualified by virtue of existing standards at the State level—for example, licensure or certification; that in the absence of those kinds of definitions, other definitions that may be represented by the professional associations for whom these individuals—with whom these individuals may be involved.

For example, the American Speech-Language-Hearing Association representing over 50,000 speech language pathologists and audiologists across the nation has for some 20 years been in the business of proposing minimum standards by which individuals ought to be qualified to provide services to the communicatively handicapped.

In the absence of either of those issues, it seems to me that the States ought to be invited to define the qualified provider as one who meets the highest available standards in existence in that State.

One of my functions at Texas Christian University is to serve as Director of the Miller Speech and Hearing Clinic. It would be unconscionable for me, I think, to invite anybody into our facility for services, let's say, with a cleft palate, and to place with that individual a person who has had no experience, no background, no training in the speech and language difficulties that are attendant to that kind of disability.

I find it difficult to understand that we can describe to parents that a handicapped child is receiving appropriate education if the individual providing those services is there and has been there on an emergency certificate, has little or no formal background experience or definition in this particular area.

In the final analysis, whatever Congress elects to do with regard to the specific wording of this legislation, we still must face the issue that the implementation is between a provider and a child or set of children. Regardless of what we say, regardless of the rhetoric that is imposed, in the absence of qualified providers the thrust, the spirit, the efficacy of this kind of program would be lost.

I appreciate the opportunity. I want at this point in time to indicate to the subcommittee that, should the American Speech-Language-Hearing Association be able to provide any assistance to you as you continue deliberations, we would be delighted to do so, stand ready to do so.

Mr. WILLIAMS. Thank you very much.

[The prepared statement of Joseph Helmick follows:]

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

STATEMENT REGARDING

THE EDUCATION OF THE HANDICAPPED ACT AMENDMENTS OF 1986

Prepared for

HOUSE COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEE ON SELECT EDUCATION

Presented by

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July 24, 1986

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Mr. Chairman and members of the Subcommittee, I am Dr. Joseph W. Helmick, Chair of the Department of Speech Communication at Texas Christian University in Fort Worth, Texas. I have over 25 years of experience as a speech-language pathologist providing services in a variety of settings, including the public schools. Since 1977, I have been responsible for the preparation of qualified speech-language pathologists, most of whom work in the schools. Currently, I am President of the 2300 member Texas Speech-Language-Hearing Association. I serve as a consultant to two Texas Special Education Co-ops and as Coordinator of Speech, Language and Hearing Screening for a local Head Start program. Today, I am also speaking on behalf of the American Speech-Language-Hearing Association (ASHA), the scientific and professional organization representing 50,000 speech-language pathologists and audiologists nationwide. In 1985, ASHA member speech-language pathologists reported that 27% of their caseloads were made up of infants and children ages birth through five. Audiologists reported that 19% of their caseloads were made up of children these same ages (Hyman, 1986).

We are pleased to have this opportunity to provide testimony related to S. 2294, the Education of the Handicapped Amendments of 1986. ASHA supports the need to increase and improve services for handicapped infants ages 0 through 2 and preschool children ages 3 through 5. However, we believe there are many questions related to S. 2294 that need to be addressed before the bill moves forward. We are pleased that the House Subcommittee on Select Education has provided a forum in which concerns related to S. 2294 can be expressed.

Mr. Chairman, no group takes more pride in the accomplishments of the Education of the Handicapped Act and PL 94-142 than do speech-language pathologists and audiologists. Of the over 4,300,000 handicapped children and youth served in 1984-85, over 2,000,000 have communication disorders. Speech or language impaired children generate over 25% of the P.L. 94-142 funds allocated to the states to provide special education and related services. Clearly, this is the most prevalent handicapping condition affecting children. However, no group is more aware of the hollow promise of this law for many handicapped children. There can be no disagreement that one key to improving the lives of handicapped infants, children and youth lies in the quality of the personnel who serve them. PL 94-142 has done much to benefit handicapped children and their families. What it has not done is ensure that handicapped children and youth receive appropriate special education and related services provided by qualified professionals.

Even though Congress expected the states to hire qualified personnel to provide programs and services for handicapped children, and even though receiving an "appropriate education" should mean receiving services from qualified personnel, states allow unqualified personnel to provide services to over 500,000 speech or language impaired children according to ASHA estimates. This number does not include the thousands of other handicapped children served by teachers and other service providers who are not qualified to provide the education they currently provide. Under PL 94-142, over $1.1 billion in federal funds are allocated to the states to provide appropriate education for handicapped children. The states get the money they deserve, but many handicapped children do not get the appropriate education they deserve. They receive services from persons who do not meet minimum standards to practice in their field, and who, in many states, could not legally provide services for adults in the same state.

ASHA believes that Congress should take a long hard look at including more children, especially handicapped infants, in a system that currently cannot ensure that all handicapped children receive an appropriate education provided by qualified professionals. To continue to call special education and related services provided to handicapped infants, children and youth by unqualified personnel appropriate education, is a disservice to the nation's handicapped children and their families. Congress has to question how the States can provide appropriate special education and related services as required by law when such services, in many instances, are provided by personnel who have not received adequate or appropriate education and training in the professional area for which they are providing services.

ASHA believes strongly that handicapped infants, children and youth deserve the appropriate education guaranteed them under the Education of the Handicapped Act. We believe Congress has a responsibility to ensure that the services provided using federal dollars are provided by qualified professionals. We believe S. 2294 has the potential to improve the quality of services for handicapped infants and children but requires consideration of some changes before it becomes the law of the land. Following are specific recommendations related to major issues of concern to the American Speech-Language-Hearing Association in S. 2294.

1. **RECOMMENDATION: Include in Part A, General Provisions, Sec. 602. Definitions, the following definition:**

> **"Qualified" means individuals who have met state established education and training standards for obtaining a license/registration to practice the profession in the state, or in the absence of such standards, have met professionally recognized standards developed by the national certification board in the appropriate profession. In the absence of licensure, registration, or national professional standards, the individual shall meet the highest standard appropriate to the professional area in which he/she is providing special education or related services.**

There can be no question that Congressional intent since the early consideration of an "Education for All Handicapped Children Act" was to ensure that children and youth would receive appropriate services from qualified personnel. For example:

A. A 1975 Senate Report states that:

> High quality educational services for all handicapped children will require a greater number of support personnel, as well as teachers. The supportive services should be provided by trained occupational therapists, speech therapists,[sic] psychologists, social workers, and other appropriately trained personnel. Senate Report No. 94-168 (emphasis added)

B. PL 94-142 requires that each handicapped child have an Individualized Education Program (IEP) which must be developed by, among others

> ...a representative of the local education agency or an intermediate educational unit who shall be qualified to provide, or supervise the provision of, specifically designed instruction to meet the unique needs of handicapped children...[Section 602(19)] (emphasis added)

C. Section 300.532 of the PL 94-142 regulations indicates that:

> Children who have a speech impairment as their primary handicap may not need a complete battery of assessments (e.g. psychological, physical, or adaptive behavior). However, a qualified speech-language pathologist would (1) evaluate each speech impaired child...(emphasis added)

D. S. 2294 in Sec. 625(d)(2) indicates that:

> Services under the individualized program shall be provided by qualified personnel. (emphasis added)

E. In the Rehabilitation Act Amendments of 1984 (PL 98-221), the term "qualified" was added to the Rehabilitation Training section in order to place greater emphasis on the use of professionals with requisite training and skill to serve disabled individuals and particularly those with severe handicaps.

> The committee's understanding of the word "qualified" as used in this amendment is certification and/or licensure by the appropriate state and/or national certifying board including but not limited to, the American Board of Certification in Orthotics and Prosthetics, the American Board of Physical Medicine and Rehabilitation, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, and the Commission of Rehabilitation Certification. (House Report 98-298)

F. Service providers in federally-supported programs such as Medicare, Medicaid, the Department of Defense, the Department of Labor and the Veterans Administration require that providers of service for the communicatively handicapped must have met state licensure standards or national established certification standards. For example, the conditions of participation under Medicare for providers of outpatient speech-language pathology services in clinics, rehabilitation agencies and public health agencies requires that services be provided by a speech-language pathologist who is defined as:

> A person who is licensed by the State in which he is practicing, if the State licenses speech pathologists [sic], and is eligible for a Certificate of Clinical Competence in Speech Pathology [sic] granted by the American Speech-Language-Hearing Association...or meets the educational requirements for certification and is in the process of accumulating the supervised clinical experience required for certification.

The ASHA proposed definition would provide similar requirements for special education and related services personnel employed in the schools.

Senator Weicker, in a statement made in the Senate on April 14, 1986 stated, "...it is no secret that the educational services for handicapped children are meaningless without qualified teachers and specialists to deliver these services." (Congressional Record, April 14, 1986, p. S4197). But even though Congress intended that services under the Education of the Handicapped Act be provided by qualified personnel, current data indicate that thousands of the nation's handicapped children and youth are provided services by individuals who are not qualified. A study by the National Center for Education Statistics (1984) found that more than one-third of special education teachers were not eligible to teach at the time they began their employment in the schools. Of 20,100 practicing teachers in special education, 6,000 were not eligible or certified to teach special education at the time they began teaching, and 2,900 had no training in special education. Of the 20,100; 8,800 were either not teaching or teaching in an area other than special education.

A study by the Institute for the Study of Exceptional Children and Youth at the University of Maryland (Smith/Davis, Burke, Noel, 1984), found that many states have resorted to issuing emergency certificates in order to fill vacancies and that one result was that special education personnel in some jurisdictions were working with handicapped children for whom they had minimal experience or preparation to provide services. The report indicates that state certification policies are often used to increase the supply of personnel, but at the expense of quality. "These same (certification) policies also make it possible for districts to increase the supply of personnel by assigning to special education those individuals who are neither prepared, qualified, nor certified to work with handicapped students." (p. 230)

Testimony provided to this Subcommittee by the American Council on Rural Special Education on August 27, 1985 concerning needs in rural special education indicated that:

> Rural areas typically have higher percentages of unqualified personnel, lower levels of certification, and higher rates of temporary and emergency certifications. Roughly two-thirds (66%) of those surveyed reported that emergency certifications were typically used in their district. They stated that temporarily certified personnel were not well qualified for the positions they held.
>
> Relatively high percentages of the rural special educators and teachers interviewed by this study reported a lack of training for their positions (e.g. 15% of the rural special education directors and teachers had taken few or no courses in special education).
>
> Emergency certification was found to be available in 92% of the districts/cooperatives represented in the survey. Eighty-three percent of the respondents indicated that emergency certification was available and frequently used; 4% available but rarely used; 5% available but never used; and 8% indicated emergency certification was not available. However, even among the 8% where it was not available only one state indicated it was inflexible on the issue if the district was in need of personnel and only uncertified applicants were available. (Helge, 1985)

In a recent study of 45 state education agencies conducted by the American Speech-Language-Hearing Association (Dublinske, 1986), 25 states indicated that they allowed waivers of the certification standards for speech-language pathologists. In 23 states that responded to a question asking the percentage of speech-language pathologists employed under waiver of the certification standards, the range was from 0-30%. Seven states used certification waivers to employ 10-30% of their speech-language pathologists.

In a study conducted by the Washington State Education Agency in 1983-84, the agency found that 19% of junior high and 21 percent of the senior high school special education classes were covered by teachers without preparation. Many other states indicate that up to 30% of their special education and related services personnel may not meet full certification standards. (Council for Basic Education, 1985)

The Congressional Research Service in its report on "Preschool Programs for the Education of Handicapped Children: Background, Issues, and Federal Policy Options" cited a study indicating that 28 states did not require teacher certification for "teaching personnel" in early childhood programs. They also indicated that the need for qualified personnel to serve preschool handicapped children was critical. (Frase, 1986)

Clearly, the data show that thousands of the nation's special education and related services personnel employed to serve handicapped children and youth are not qualified to provide these services. Another problem exists when the state has certification standards for professionals employed in the schools that do not meet the professional education standards included in a state's licensure law or accepted national professional standards for certification.

For example, since 1965, the American Speech-Language-Hearing Association has promoted the master's degree as the minimum accepted level of preparation for employment as a speech-language pathologist or audiologist. The decision to establish the master's as the minimum level of preparation for employment as a speech-language pathologist was made following a national two-year Office of Education funded study completed in 1961 of speech-language and hearing programs in public schools. The results of the study (which included responses from ASHA members and nonmembers) showed that 98% of 1,800 respondents indicated that graduate education was desirable if not essential in providing services in the schools. The majority of the respondents favored a five-year minimum training requirement.

In 1963, a national conference on the issue of graduate education in speech-language pathology and audiology was held. The 105 experts in the profession attending the conference overwhelmingly agreed that the minimum educational level for speech-language pathologists should be the master's (M.A.) degree or equivalent. Currently, the professionally accepted level of education and practicum for certification as a speech-language pathologist includes the following:

- A graduate degree with specific study in human communication. The course of study includes psychology, anatomy, physiology, sociology, neurology, acoustics, linguistics, psycholinguistics, speech reading, clinical psychology, and education and training in diagnosis, appraisal, and remediation of speech, language, and hearing disorders.
- 300 clock hours of supervised clinical experience.
- Nine months of full-time professional experience under supervision of an individual who holds the Certificate of Clinical Competence.
- A passing score on a national examination in speech-language pathology.

The question typically asked in discussions related to personnel qualifications is: "Is a master's degree really better than a bachelor's?" In a review of 50 randomly selected transcripts and practicum records submitted to ASHA by students seeking the Certificate of Clinical Competence, the data clearly show that individuals who would have terminated their education and training at the bachelor's (B.A.) level would not have been qualified to provide services. For example, only 24% of the B.A. level students had taken a course in diagnostics. Only 40% had taken a course in language disorders and only 46% in articulation. These are the two major communicative disorders found in communicatively handicapped school age children. Forty-two percent of the B.A. level individuals had less than 100 hours of practicum. Twenty-four percent had no practicum hours. In an ASHA study of terminal baccalaureate programs in speech-language pathology, data indicate the average number of practicum hours received was 152, nearly 50% less than required for clinical competence. (Snope, 1982a)

In a recent ASHA study (Snope, 1982b) of the competencies of bachelor and master level speech-language pathologists, respondents were asked to rate their competency on 38 skills necessary to conduct a comprehensive speech-language pathology program. Seventy-six and three-tenths percent of a randomly selected population of 2,554 BA and MA speech-language pathologists responded. On 34 of the 38 skills, individuals with bachelor's degrees rated themselves lower than individuals with a master's degree. Bachelor's level persons rated themselves as having high competence in only five of 38 skills:

1. Treat persons with articulation disorders
2. Evaluate persons with articulation disorders
3. Select individuals for caseload
4. Establish treatment plans based on assessment data
5. Use assessment data to terminate services

I suggest that Congress does not want persons with minimal qualifications providing services for handicapped infants, children and youth in the nation's schools.

Even after 20 years of having a national certification standard requiring the master's degree for certification as a speech-language pathologist, only 23 states require the MA degree (Appendix A). A 1986 ASHA study of 35 state education agencies found that 29% of the speech-language pathologists employed (N=6,664) had a bachelor's degree. Thirty states indicated that 285,283 communicatively handicapped children and youth were provided services by individuals with professional education that was less than the master's degree. (Dublinske, 1986) These handicapped individuals are generating over $68 million in PL 94-142 funds even though they are being provided services by unqualified providers. Projected for all 50 states, ASHA estimates that nearly 40% of the personnel providing services for the speech or language impaired do not meet accepted professional education standards. This means that over 500,000 and possibly up to 800,000 communicatively handicapped children could be served by unqualified providers.

Some individuals suggest that determination of professional qualifications is a state responsibility and that Congress should not interfere by writing standards into federal law. The proposed definition of qualified does not establish a mandated national certification/licensure standard. It does, however, require that states adhere to the highest standards they have established in the state for employment in a profession or teaching in a specific professional area, and apply to personnel serving children in the schools the same high standards that the state already requires in other public and private settings for services to adults. For example, 36 state legislatures have passed licensure laws indicating that to protect the health, safety and welfare of consumers of speech-language pathology in the state, services must be provided by a professional who holds the master's degree. However, in 19 of these same states the state education agency allows handicapped children to be provided services by individuals who hold less than a master's degree. (Appendix B) ASHA believes strongly that handicapped infants and children should not be discriminated against just because they happen to receive services in the schools. If the proposed definition of "qualified" were included in S. 2294, the 19 states that now permit this double standard would have to adopt the education and training requirements of the highest state standard as the minimum certification level for employment in the schools, thus ensuring that handicapped children would receive the same high standards of service that the state requires for consumers in other settings. ASHA does not view this as federalization of a state responsibility.

The overall impact of the proposed definition of "qualified" would be that states would have to adopt state education agency certification standards that were at least as high as those already required by the state legislature in any existing licensure law applicable to the practice of a profession in the state. In the absence of a licensure law, the state would have to adopt certification standards that meet professionally recognized standards for that profession. The definition also would require that teachers of special education would have to meet full certification standards for the professional area in which they are teaching. For example, if the state had specific requirements for certification as a teacher of the learning disabled or the emotionally disturbed, individuals teaching in those areas would have to meet the specific certification requirement established by the state. Thus, an elementary class teacher with no coursework in teaching the emotionally disturbed would not be allowed to teach a self-contained class of emotionally disturbed students. ASHA does not see this as an unreasonable requirement in view of the unique needs of handicapped children and the amount of federal assistance to the states to support the provision of appropriate education for all handicapped children.

We are concerned also that some individuals do not want to include the definition of "qualified" in the law because some school districts in rural areas have difficulty recruiting and retaining qualified personnel. Unfortunately, many of these individuals hold the belief that because these handicapped children are served in the schools, in a rural area, they do not need to have services provided by "qualified" professionals. ASHA believes the professional working in the rural and remote area needs to be highly qualified because they do not have the various support systems available to professionals in urban/suburban areas. We believe that states need to improve salaries and working conditions to attract qualified personnel and not promote reducing standards so that less qualified personnel can be employed as has been attempted in eight states during the past three years.[1] The determination of what modifications need to be made in program standards and personnel requirements to accommodate those areas that have difficulty in recruiting and retaining qualified professionals should be handled at the state level and on a district by district basis as the need arises.

The proposed definition of "qualified" is important as Congress considers expanding services to infants and preschoolers with handicapping conditions. In 1984-85, there were 259,483 handicapped children served ages 3-5. Of this number, 183,021 or 70% had a primary handicap of speech or language impairment. (U.S. Department of Education, 1986) This number does not include the large number of handicapped children with other handicaps (e.g. mentally retarded, learning disabled, hard of hearing, deaf, multihandicapped) who have concomitant communicative disorders. Clearly, S. 2294 with its mandate for services to handicapped children ages three through five and proposed early intervention program for handicapped infants age birth through two, will promote an increase in the demand for services. Handicapped infants and preschool children who require early intervention services exhibit some of the most severe handicaps. ASHA believes they have a right to services provided by qualified professionals.

ASHA realizes there is a point of view suggesting that determining the qualifications of providers of service is a state issue and should not involve Congress. However, we also believe Congress has a responsibility to ensure that the $1.16 billion now being spent for PL 94-142 State Grants and the $200 million authorized for state grant services for the 0-5 age population are not being spent on services provided by unqualified personnel. Based on existing data that show that approximately 25% of all special education and related service personnel do not meet full state certification or national certification standards, up to 120,000 special education and related service personnel might be unqualified to provide programs and services for handicapped children whom they currently are serving. Assuming each provider serves an average of 10-15 students, up to $400,000,000 of Education of the Handicapped funds could be spent on programs and services provided by unqualified providers of service. ASHA finds it hard to believe that Congress would continue to support the mandating of programs and services to more handicapped infants and children and the appropriation of millions of more dollars for education of handicapped children without ensuring that this money is spent on programs and services provided by qualified professionals. We believe that handicapped children have a right to receive services from qualified personnel. We believe Congress has an obligation to encourage states to employ qualified personnel by defining in law what the term "qualified" means.

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[1] Connecticut, Illinois, Kansas, Massachusetts, Mississippi, Nebraska, Vermont, Idaho.

2. RECOMMENDATION: Change the definition of handicapped infants to read as follows:

> The term "handicapped infants" means individuals from birth through age two who are, or who are at risk for becoming developmentally delayed, or children with specific congenital or acquired conditions who by reason thereof require early intervention.

Many handicapped children require more intensive special education and related services than may have been necessary because they did not get the necessary early intervention services when they were at risk. As currently written, the definition does not make it clear that infants who are at risk for becoming developmentally delayed would be eligible to receive intervention services. The intent is not to open up the definition to all infants who may be defined as "at risk." However, for those infants born with conditions and syndromes that may lead to developmental delay at a later date, it is necessary to ensure that they receive the necessary intervention services that will ameliorate the problem.

3. RECOMMENDATION: Amend Sec. 623 or Sec. 629 to include the following statement related to the state's use of funds allocated under Subpart 2:

> Each state shall establish procedures to ensure that funds allocated to the state agency under Subpart 2 shall be used to support services for early intervention programs only after all other state, federal and public and private insurance sources for funding of early intervention programs and services have been exhausted.

Although Sec. 624(a)(2)(A) indicates that the Early Intervention Council shall ensure that each state agency is making a financial contribution to support early intervention programs, and even though Sec. 629 indicates that public and private support for early intervention programs should continue; there is no real procedure in the proposed bill that will ensure that public and private agencies and insurance programs will maintain current funding once federal funds under Subpart 2 are available for use. It is recommended that a "last dollar" concept be implemented to govern the use of Subpart 2 funds. Implementation of the "last dollar" concept would require that states use all other funds available to pay for early intervention programs and services before Subpart 2 funds could be used.

4. RECOMMENDATION: Sec. 622(2)(A) should be amended to read as follows:

> For each fiscal year from the remainder of the funds, the Secretary shall allot to each state an amount which bears the same ratio to the amount of such remainder as the number of eligible infants in the state...

Sec. 622(2)(C) should be eliminated.

As currently written, S. 2294 requires that payments under Subpart 2 be allotted to the states based on a census of infants ages 0 through 2 for two years and then on the number of handicapped infants served. It is recommended that payments to the states for the early intervention program be allotted to the states based on a census formula from the inception and for the duration of the program. Following the first three years of the program, the census formula could be weighted to include a premium based on the number of handicapped infants served. The census formula also could be weighted using factors such as socioeconomic status to ensure that states that may have a high concentration of handicapped infants are allotted funds based on their potential need.

5. RECOMMENDATION: Sec. 628 needs to be clarified to show the relationship between the planning, development, and implementation grants under this Section; the comprehensive early childhood plan for services indicated in Sec. 673; the planning, development and implementation grants funded under the current Part C, Sec. 623, Early Education for Handicapped Children and Sec. 4(b). It is recommended that the specific date for having a comprehensive plan developed and providing programs and services under Sec. 4 and Subpart 2 be established as September 1, 1990. It is recommended also that the state be required to develop only one comprehensive

plan that includes the provision of programs and services for all handicapped children birth through age five.

It is not clear what the planning requirements are related to Subpart 2 in relation to current state planning activities under Sec. 623 and timelines related to completing those plans. All states have received planning grants under Sec. 623 and have made progress towards developing a comprehensive state plan for serving handicapped infants and children ages 0 through 5. Some states already have mandates for serving handicapped infants from birth through age five. Other states have mandates for serving some handicapped infants and children in this age range. Still other states mandate services for handicapped children ages three through five, while other states do not require services until a handicapped child enters school. It is obvious that states are in various stages of planning and providing programs and services for handicapped children ages birth through five. States that do not have laws, rules and regulations that allow for the provision of preschool services will need time to develop appropriate policies. The proposed Early Intervention Council will need time to plan the early intervention program. Planning activities funded under the current Sec. 623 are to be completed in 1990. Thus, a specific date of September 1, 1990 would provide a target date for the states by which they are to have their comprehensive state plan completed and have the necessary programs and services available for handicapped infants and children birth through age five.

6. **RECOMMENDATION: Clarify Sec. 625(c)(3) which requires that each handicapped infant shall have access to all services described in the early intervention program plan without cost, to the extent nor inconsistent with federal or state law, to the parent or guardian.**

It is recommended that the terms "health services," "special education," and "social services" be defined. Services included in the intervention program plan may include special education, health and social services. Senate Report 99-315 accompanying S. 2294 indicates that health services may be provided on a sliding fee scale but that special education shall be at no cost. There is no definition of what is meant by "health services," "special education," or "social services." Therefore, it is unclear just what programs and services for infants birth through age two would be provided at no cost. Also what does, "...to the extent not inconsistent with federal or state law..." mean? Does this mean that the needy parents who may be required by federal or state law to pay a copayment to receive services under Medicaid do not get services at "no cost?" If, as indicated in Sec. 629, all other payors for services are to continue to pay for services, and parents are to pay for health services on existing sliding fee scales, and all service are to be provided at no cost only when not inconsistent with federal or state law, it is unclear what the $100,000,000 authorised for services is to be used for by the states. If "special education" is the only service to be provided at no cost, why include health and social services in the program planning?

7. **RECOMMENDATION: There is a need to clarify just what the $100,000,000 authorised for the early intervention program will be used for by the states.**

It is unclear in S. 2294 just what the Subpart 2 funds will be used for by the states. Because of the planning requirements during the first three years, it doesn't appear that a significant amount of the funds will be used to provide direct programs and services. Also, the entire program requires extensive management and coordination. It is conceivable that a considerable amount of funds could be used to obtain necessary assessments, develop individualized program plans, provide transportation to services, and to provide necessary aids and devices. Because allotments will be going to each state based on census, the allotted funds have characteristics similar to a "block grant" that can be used to plan and provide an early intervention program. If all services but "special education" are to be paid for using existing funding sources, the term "special education" needs to be defined so states know what Subpart 2 funds can and cannot be used for in the state.

8. **RECOMMENDATION: Change Sec. 625(c)(2) to read:**

> **"...a written individualized program plan developed by a multidisciplinary team, including the parent or guardian describing the services needed to meet the unique needs of the handicapped infant and family unit which may include but is not limited to..."**

The term "necessary services" is not clear. The recommended change makes it clear that the services are to meet the unique needs of the handicapped infant and the family unit. It also will be important to define some of the terms included under the list of services in Sec. 625(c)(2). For example, what is included in "health services?" Does it include some medical services? What are "special education services" for handicapped infants? Does this include audiological services, speech-language pathology, occupational and physical therapy and other services that must be provided at "no cost?" What is included in "social services?" Definitions for these terms become important in determining what is to be included in the Individualized Program Plan and determining what programs and services are to be provided at no cost. The bill as currently written excludes surgical and hospitalization services. However, for many handicapped infants these are the most necessary services they need during the early months of their life. Many services for handicapped infants are provided while they are in the hospital. There is a need to clarify what necessary and unique surgical or hospitalization services that are needed by a handicapped infant should be included under Subpart 2.

9. **RECOMMENDATION: Clarify the role physicians will have in planning and implementing early intervention services.**

Subpart 2 of S. 2294 requires an integrated plan for providing programs and services that includes health, education and social services. Sec. 625(c)(1) requires a multidisciplinary assessment of individual needs and services required to meet such needs. Does this include assessment by a physician? Is the physician supposed to refer all infants suspected of being at risk for developmental delay or who have congenital or acquired conditions to a team of other health, education and social service providers? Is the physician to be part of the multidisciplinary team developing the intervention program plan? Are physician services included in the Individualized Program Plan to be provided at no cost? Are physician services subject to the procedural safeguard provision of Sec. 626? Clearly, physicians play an important role in early intervention for handicapped infants. However, their role and its impact on the programs and services provided under Subpart 2 is not clear as the bill is presently written.

10. **RECOMMENDATION: Services for handicapped children ages three through five should be mandated on the same basis as for handicapped children ages 6-17. Funding for planning and providing programs and services should be on a census basis until September 1, 1990 and then based on a child count of handicapped children served thereafter. Following September 1, 1990 there should be no special incentive for serving handicapped children ages 3 through 21. To accommodate those states that currently serve handicapped children ages three through five, the census formula should include a premium based on the number of handicapped children served.**

The result of mandating services for handicapped children ages 3 through 5 should be to bring them under the coverage of PL 94-142 without the use of incentives. The same procedures and requirements that apply to handicapped children ages 6-17 under PL 94-142 should apply to handicapped children ages 3 through 5. Unfortunately, S. 2294 does not provide an adequate funding mechanism for planning and providing services for handicapped children in this age group. Currently, funds are allocated based on the number of handicapped children served. Therefore, federal funds are not made available until after the children are served. Many states are not serving all handicapped children ages 3 through 5. Therefore, to comply with the mandate, many states would have to put up all of the necessary money to initiate the program while waiting up to two years before the child count makes federal assistance possible. By providing federal funds appropriated for serving children ages 3 through 5 on a census basis until September 1, 1990 (the date when the comprehensive state plan for serving all handicapped infants and children birth through age 5 is to be implemented) states would have the funds to plan and implement a comprehensive program. After that date, PL 94-142 state grant funds that are regularly allocated to states on the basis of a child count would be used for all children served ages three through 21. The preschool incentive grant program would no longer be necessary.

11. **RECOMMENDATION: Clarify what will happen to Subpart 2 after the three years covered by S. 2294. Consider a permanent authorization for the early intervention program with provisions for regular Congressional oversight and review on at least a triennial basis.**

It is unclear in Subpart 2 of S. 2294 what will happen to the early intervention program after the three years covered by this bill. Essentially, the first three years appear to be planning years and are permissive for the states. After the planning years are over, it is unclear what will happen next. There is not much incentive for a state to initiate an early intervention program that will require a considerable amount of state funds when there is no assurance that there will be a continuing federal commitment after three years. A permanent authorization, like that for PL 94-142 would be helpful in providing an incentive for states to get involved in the Subpart 2 program.

12. **RECOMMENDATION: A provision should be included in the bill that mandates interagency coordination of federal programs and agencies providing funding for handicapped infants and children.**

If the states are going to be required to initiate interagency cooperation and coordination in order to provide effective services for handicapped infants and children, it would seem appropriate that federal agencies providing funds for programs and services for handicapped infants and children also would be required to cooperate and coordinate activities. For example, coordination should take place among federal agencies that provide screening, diagnosis,and treatment; Head Start; Chapter 1 programs (PL 89-313); Medicaid; early childhood education and other programs responsible for handicapped infants and children. If states are going to be required to coordinate funds from all of these programs to provide comprehensive services, the federal agencies responsible for the programs should serve as a model for the states in how such coordination should take place.

13. **RECOMMENDATION: The term "developmentally delayed" for identifying handicapped children ages three through five should be used only when no other primary handicap can be identified.**

In some instances it is difficult to identify categorically many of the handicapped children ages three through five, e.g., learning disability, seriously emotionally disturbed, mentally retarded. The discussion of use of the term in Senate Report 99-315 (p. 6) is helpful in defining the term and discussing the rationale for its use. However, handicaps such as speech or language impairment are more easily identified and should be used if that is the primary handicap identified. Such categorical designations are useful in planning for personnel, programs and services, continuing education and research.

14. **RECOMMENDATION: Under Sec. 633(b)(1) the 10 percent set-a-side for the provision of training and technical assistance should be limited to training of needed personnel.**

The authorization of funds for Part D--Training Personnel for the Education of the Handicapped should be increased by a minimum of $10 million over the current proposed authorization level and the funds targeted to those states that document shortages of qualified personnel.

One of the major reasons states give for not requiring that qualified personnel be used to provide special education and related services in some professional areas is the shortage of qualified personnel. ASHA believes states need to commit state funds to increasing the number of qualified personnel available within their state. At the same time, the federal government needs to increase its commitment to ensuring that there are sufficient numbers of qualified personnel to provide the programs and services mandated by federal law. An increased appropriation for Part D of the Education of the Handicapped Act and a special set-a-side in Sec. 633 will be of assistance to those states that want to increase the number of qualified providers of service in their state.

SUMMARY

Mr. Chairman, I thank you for the opportunity to provide these recommendations to the Subcommittee. The American Speech-Language-Hearing Association appreciates your willingness to obtain information that will, in our opinion, lead to development of a bill that will meet the needs of handicapped infants and children. We believe strongly that the recommendations made in this statement will improve S. 2294 and should be considered as your Subcommittee considers the reauthorization of the Education for the Handicapped Act and the development of legislation related to early intervention programs for handicapped infants.

The major concern addressed in this statement is that thousands of handicapped children are not receiving an appropriate education as mandated by PL 94-142 due to the lack of use of qualified personnel to provide such education. Although ASHA strongly supports the need to increase and improve services for handicapped infants and children ages birth through five, we urge Congress to make sure that any new initiative in this area will ensure that the special education/health services, social services and other programs needed by handicapped infants and other preschool children are provided by professionals whose education and experience qualifies them to deal appropriately with the unique needs of these children.

For further information on any of the recommendations included in this statement, contact Dr. Stan Dublinske, Director, State and Regulatory Policy, American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, MD 20852, (301) 897-5700.

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APPENDIX A

Speech-Language Pathology Certification Requirements for the Public Schools

	BA	MA or Equivalent	Other Combinations
Alabama	BA		
Alaska	BA		
Arizona	BA		
Arkansas			Level 1: BA 6 yr. nonrenewable Level 2: MA 10 yr. renewable
California		MA	
Colorado		MA	
Connecticut		MA	
Delaware		MA	
Florida	BA		MA effective 7/1/89
Georgia			Entry level BA - 5 yrs. nonrenewal requires MA; MA effective 9/1/87
Hawaii		MA	
Idaho		MA	
Illinois		MA	
Indiana		MA	
Iowa		MA	
Kansas		MA	
Kentucky			Entry level BA after 10 yrs. renewal requires MA; MA effective 9/1/87
Louisiana	BA		MA effective 1990
Maine			Entry level BA 5 yr. term + 1 renewal (10 years total) then renewal requires 30 hrs.
Maryland			BA - provisional MA - Standard Professional Certificate
Massachusetts		MA	
Michigan		MA	
Minnesota	BA		
Mississippi		MA	
Missouri	BA		MA effective 9/1/86
Montana		MA	
Nebraska		MA	
Nevada	BA		
New Hampshire		MA	
New Jersey	BA		
New Mexico		MA	
New York			Entry level BA - after 5 yrs. renewal requires MA.
North Carolina		MA	
North Dakota	BA		
Ohio	BA		MA effective 1/1987
Oklahoma			Entry level BA - after 4 yrs. renewal requires MA
Oregon	BA		

APPENDIX A
(cont.)

	BA	MA or Equivalent	Other Combinations
Pennsylvania			Entry level BA Instructional Certificate I after 3 yrs. renewal requires Instructional Certificate II - 24 credits
Rhode Island			Provisional Certificate - BA 4 yr. nonrenewable. Requirements: BA + 24 hours required coursework and minimum 6 hours of supervised clinical experience. Professional Certificate - MA or 36 hours beyond BA degree including 15 hours of graduate coursework in speech/language pathology + 3 years professional experience.
South Carolina	BA		
South Dakota	BA		
Tennessee	BA		
Texas		MA	
Utah			BA entry level - BA - 5 yr. nonrenewable - after 5 years requires MA or equivalent
Vermont		MA	
Virginia	BA		
Washington		MA	
West Virginia		MA	
Wisconsin		MA	
Wyoming			BA + 12 professional courses
District of Columbia	BA		
TOTAL	17	23	11

GAD/6-5-86

APPENDIX B

State Qualifications for Employment for Speech-Language Pathologists

LICENSURE* REQUIRED FOR EMPLOYMENT IN ALL SETTINGS

Connecticut
Delaware
Hawaii
Kentucky (*effective 9/1/87)
Massachusetts
Montana

MA CERTIFICATION**/LICENSURE

California
Georgia (MA effective 9/1/87)
Indiana
Iowa
Mississippi
Missouri (MA effective 9/1/86)
Nebraska
New Mexico
North Carolina
Ohio (MA effective 1/87)
Texas

MA CERTIFICATION/NO LICENSURE

Colorado
Idaho
Illinois
Kansas
Michigan
New Hampshire
Vermont
Washington
West Virginia
Wisconsin

BA CERTIFICATION/LICENSURE

Alabama
Arkansas
Florida (MA effective 1989)
Louisiana (MA effective 1990)
Maine
Maryland
Nevada
New Jersey
New York
North Dakota
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Utah
Virginia
Wyoming

BA CERTIFICATION/NO LICENSURE

Alaska
Arizona
District of Columbia
Minnesota
South Dakota

Licensure laws for speech-language pathologists have been enacted in 36 states. The minimum degree required to obtain a license in all 36 states is a Master's degree.

Certification is issued by the state education agency and is needed to practice speech-language pathology in the public schools. MA = Master's degree and BA = Bachelor's Degree and signifies the minimum education required to obtain certification.

Mr. **Williams**. John Watts, a parent from Wall Township, New Jersey, is here representing the National Society for Children and Adults with Autism.

We're pleased you're here and eager to hear from you.

TESTIMONY OF JOHN WATTS, NATIONAL SOCIETY FOR CHILDREN AND ADULTS WITH AUTISM

Mr. **Watts**. Mr. Chairman, members of the subcommittee, thank you very much for inviting me here today. Again, my name is John Watts of Wall Township, New Jersey. I'm the parent of three children, and my middle child, Wendy, who is 8 years old was born with a neurological disorder, autism.

I'm here today to testify on the need for early intervention services for infants and preschoolers with autism and other disabilities. I'm testifying on behalf of the National Society for Children and Adults with Autism, NSAC. NSAC was founded in 1965 by parents and is dedicated to the education and welfare of all persons with severe disorders of communication and behavior. Autism is the fourth most prevalent developmental disability in this country. Autism is a lifelong brain disorder that prevents the proper understanding of what a person sees, hears or otherwise senses.

Autism typically appears during the first 3 years of life and causes severe problems in learning, communication and behavior. It is not a mental illness. Autism is treatable. Early diagnosis and intervention are vital to easing and/or potentially eliminating the symptoms of autism.

We would like to introduce Dr. Dave Holmes. If there's any technical questions, he's the Director of the program that Wendy goes to, Eden Institute, which is in Princeton. My wife, Kathy; my daughter, Wendy, 8, who has autism; and my 6 year old daughter, Crystal.

My daughter Wendy was diagnosed as having autism when she was 2. She is presently enrolled in a fine program at Eden Institute in Princeton, New Jersey. I'm here today to tell the subcommittee about my years and my wife's years of struggle for preschool services for our daughter.

Up until 2 years of age, Wendy appeared to be fine. Just after her second birthday, my wife Kathy and I sensed that there was something wrong. She had stopped the little talking that she had acquired. She was not playing with any of the children in the neighborhood and did not respond to her older brother or her baby sister, Crystal.

We took Wendy to a number of professionals, including her pediatrician, our family doctor and even the local hospital. Nobody knew what was wrong with her. During this time, Wendy had stopped developing and was beginning to regress. She began drooling, walking aimlessly around our house. We seemed to be losing her to something that we didn't understand.

Finally, at two and a half, our family doctor felt it was time for Wendy to see a specialist. We were referred to a pediatric neurologist who confirmed that Wendy indeed had developmental problems and that, specifically, our little girl was suffering from autism.

It was a bittersweet victory to find out what was wrong with Wendy. On one hand, my wife and I were happy that a professional agreed that our daughter was not developing normally. On the other hand, this problem called autism was devastating to us as the doctor explained the seriousness of the syndrome.

Our neurologist had no further recommendations on what to do with Wendy, except to possibly enroll her in a preschool handicapped program. At this point, we contacted our local school district, Wall Township. Within 2 months we finally met with them and received discouraging news. They told us they had nothing for our daughter.

They did, however, tell us about a preschool handicapped program in the next school district. Imagine our frustration when we went to this program and found out there were no openings. We did not know where to turn.

Then imagine our joy when we learned shortly thereafter, approximately two weeks later, that there was an opening for our daughter. Finally, something was going to be done for our daughter, Wendy.

Wendy started school at age 3 years and 2 months. However, our joy was shortlived. To our utter dismay, the teacher agreed with my wife and myself that this program was not appropriate for Wendy. Thus began our battle to find and have Wendy placed in a program suited to her specific needs, an appropriate education.

Our first course of action was to go back to our school district and ask them to help. The school district flatly refused to help us any further, telling us we're doing more than we are required.

At this point my wife and I started calling around the State to several programs, and learned of Eden Institute in Princeton. We visited the school that serves only those with autism and were overjoyed to find other children like Wendy and, more significantly, they were treating and working with children like Wendy appropriately.

We went back to our Board of Education and relayed our story to them. The Board concurred with the school administration that they would do nothing for her at that point. In total frustration, we contacted the office of the Public Advocate who requested a due process hearing for Wendy.

Meanwhile, Wendy was becoming harder and harder to manage. She was breaking things in our house, and my wife and I had to constantly watch her. When I'm saying breaking things in our house, she would break lamps. She would pull things off the table, throw things.

Crystal was, and this isn't in here, Crystal was hit with a sharp knife by Wendy on the head, as part of the violent behavior that she was exhibiting. We didn't know what to do.

What do you do when you're a father and your second oldest child stabs your baby daughter, and she doesn't even know she's doing it, and no one is able to help you?

Finally, we heard from Eden Institute that they would accept Wendy,—and we did it then, too. We cried. While due process was in place, my wife and I decided to start Wendy in this program as soon as we could, even though the hearing wasn't completed. We began transporting her—mostly Kathy—on a one hour commute each way to Princeton.

Finally, in June of 1984 our district, Wall Township, agreed to formally place Wendy in the Eden program. The program had already been serving her for 2 years before they decided to place her there.

Through our battle, which we had won, the emotional and financial burden had already taken its toll. Again, another bittersweet victory for Wendy and our family. She was now 5 years old, and we were already tired. Exhausted.

It was the very same summer in 1984 that the State of New Jersey passed legislation mandating education for preschool handicapped children. Wendy was now 5 years and 11 months old.

For Kathy and me, there was some consolation in knowing that other families would not have to go through this. No one in our society, in this country, the United States of America, the richest country in the world, should live through this kind of experience.

The early developmental years in the life of a child with autism are crucial. The disability that these children suffer and the stresses that the entire family encounters in the early years when the child is first diagnosed require that families be supported and worked with for the maximum potential and again an appropriate education for their child.

Early intervention in the form of counseling, guidance from professionals and the existence of support groups such as the Institute and the National Society for Children and Adults with Autism, NSAC, have helped to prevent and ease the potentially devastating complications of autism.

I know that NSAC believes that every State should have quality early intervention and preschool programs available to every child with a handicap. NSAC supports the mandate for preschool services from the age of three and supports the goal that all children with handicaps from birth upward have available to them quality therapeutic educational and social services to enhance their lives.

There is a need for in home, center and community based programs with an emphasis on the family. The parents have to know what to do with the child when they're not in school. Ultimately, education and health services from birth should be mandatory for children with handicaps.

If the program of services doesn't start until age of 3, the battle has been half lost. The parenting of our daughter Wendy has been filled with hope and pride in her accomplishments. She's been sitting here. She was down when the other bill was passed down in the House of Representatives earlier, and she wouldn't sit for 2 seconds—2 seconds. Imagine trying to hold a kid down, fighting you, if it's more than 2 seconds; and she didn't know what she was doing. This was when she was 2 years old, and by the age of 3 it was worse. Now she sat for darn close to 4 hours; and if you hear her making her screams and voices, it's probably from joy from being down here and hearing what's going on, although she really doesn't understand it. She just gets the feel for it. But that's what's happened in the last 2 years with Wendy.

These accomplishments come in no small part to the fact that my wife Kathy and I took it upon ourselves to challenge the system and receive preschool programming. For years we have fought the stereotype that nothing can be done or that she will grow out of it. Children with autism and other handicaps cannot wait while we debate the cost effectiveness of their need for preschool education.

Although it's been said before in this room, and I've heard it other places, and it was in the seventh annual report which I went by. It was in the seventh annual report from the Department of Education that it is cost effective to start early with children with handicaps.

The 10 years of progress since the passage of Public Law 94-142 should be continued and expanded. Further, the savings in human costs are immeasurable, because early intervention prevents a multitude of problems later in the lives of children with autism and their families.

I want to thank you very much for the opportunity to share my daughter's story and our family's story in front of the subcommittee today.

Thank you very much.

Mr. WILLIAMS. Our thanks to you, Mr. Watts, and also to your family. We appreciate not only your message but your effort in bringing it to us.

[The prepared statement of John Watts follows:]

NSAC National Society for
Children and Adults with Autism

STATEMENT RESPECTFULLY SUBMITTED

TO THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ON THE EDUCATION FOR THE HANDICAPPED

ACT AMENDMENTS OF 1986

BY

JOHN WATTS

ON BEHALF OF THE

NATIONAL SOCIETY FOR CHILDREN AND ADULTS

WITH AUTISM

JULY 24, 1986

1234 Massachusetts Ave., N.W., Suite 1017, Washington, D.C. 20005 (202) 783-0125

Mr. Chairman and Members of the Subcommittee:

I am John Watts of Wall Township, New Jersey. I am the parent of three children, and my middle child, Wendy who is eight years old, was born with the neurological disorder, autism. I am here today to testify on the need for early intervention services for infants and preschoolers with autism and other disabilities. I am testifying on behalf of the National Society for Children and Adults with Autism (NSAC).

NSAC was founded in 1965 by parents and is dedicated to the education and welfare of all persons with severe disorders of communication and behavior. Autism is the fourth most prevalent developmental disability in this country. Autism is a lifelong brain disorder that prevents the proper understanding of what a person sees, hears, or otherwise senses. Autism typically appears during the first three years of life and causes severe problems in learning, communication and behavior; it is not a mental illness. Autism is treatable. Early diagnosis and intervention are vital to easing and/or potentially eliminating the symptoms of autism.

My daughter, Wendy, was diagnosed as having autism when she was two years old. She is presently enrolled in a fine program at the Eden Institute in Princeton, New Jersey. I am here today to tell the Subcommittee about my years of struggle for preschool services for my daughter.

Up until two years of age, Wendy appeared to be fine. Just after her second birthday, my wife, Kathy, and I sensed that there was something wrong. She was not talking or playing with any children in the neighborhood and did not respond to her older brother.

We took Wendy to a number of professionals, including her pediatrician, our family doctor, and even the local hospital. Nobody knew what was wrong with her. During this time, Wendy had stopped developing and was beginning to regress. She began drooling and walking aimlessly around our house. We seemed to be losing her to something we did not understand.

Finally, at two and a half years her family doctor felt it was time for Wendy to see a specialist. We were deferred to a pediatric neurologist who confirmed that Wendy indeed had developmental problems and that specifically our little girl was suffering from autism. It was a bittersweet victory. On one hand, my wife and I were happy that a professional agreed that our daughter was not developing normally. On the other hand, this problem called autism was devastating to us as the doctor explained the seriousness of the syndrome.

Our neurologist had no further recommendations on what to do with Wendy except to possibly enroll her in a preschool handicapped program. At this point we contacted our local school district. Within two months, we finally met with them and received discouraging news. They told us they had nothing for our daughter.

They did, however, tell us about a preschool handicapped program in the next school district. Imagine our frustration when we went to this program and found out there were no openings. We did not know where to turn. Then imagine our joy when we learned shortly thereafter that there was an opening available for our daughter. Finally, something was going to be done for Wendy.

Wendy started school at age three years and two months. Our joy was short lived. To our utter dismay, the teacher and my wife and I agreed that this program was not appropriate for our daughter.

Thus began our battle to try to find, and have Wendy placed in, a program suited to her specific needs. Our first course of action was to go back to our school district and ask them to help find another placement for our child. The school district flatly refused to help us any further, telling us that "We're doing more than what is required of us."

At this point, my wife and I started calling around the state and learned of the Eden Institute in Princeton. We visited this school that serves only those with autism and were overjoyed to find other children like Wendy and, more importantly, that they were doing something with them.

We went back to our Board of Education and told them our story. The Board concurred with the school administration that they would do nothing for her.

In total frustration, we contacted the office of the public advocate who requested a due process hearing for Wendy. This was nine months after Wendy had been dismissed from her program. Meanwhile, Wendy was becoming harder and harder to manage. She was breaking things in our house, and my wife and I had to constantly watch her.

Finally, we heard from the Eden Institute that they would accept Wendy in their preschool program. We both cried. While the due process was in place, my wife and I decided to start Wendy in the preschool program as soon as possible. We began transporting her in the one hour commute, each way, to Princeton. You can imagine our relief when the Eden administrator informed us he would not charge us tuition until due process was complete.

It was not until approximately one year later in November, 1983, that the due process hearing actually began. During this time we continued the long commute. Finally, in June of 1984, Wall Township, our school district, agreed to formally place Wendy in the Eden preschool program that had been serving her so well for the previous two years.

Though our battle had been won, the emotional and financial burden had taken its toll. Another bittersweet victory for Wendy and our family. She was only five years old, and already we were tired.

It was that very same summer of 1984 that the state of New Jersey passed legislation mandating education for preschool handicapped children. For Kathy and me there was some consolation in knowing that other families would not have to go through what we lived through. No one in our society, the richest country in the world, should have to live through this kind of existence.

The early developmental years in the life of a child with autism are crucial. The disability that these children suffer, and the stresses the parents encounter in the early years when the child is first diagnosed, require that families be supported and worked with for the maximum potential of their child. Early intervention in the form of counseling, guidance from professionals, and the existence of support groups such as the Eden Institute and the National Society for Children and Adults with Autism have helped to prevent and ease the potentially devastating complications of autism.

I know that NSAC believes that every state should have quality early intervention and preschool programs available to every child with a handicap. NSAC supports the mandate for preschool services from age three and supports the goal that all children with handicaps from birth upward have available to them quality therapeutic, educational and social services to enhance their lives. There is a need for in-home, center and community-based programs with an emphasis on the family. Ultimately, education and health services from birth should be mandatory for children with handicaps; if the program of services doesn't start until age three, the battle has been half lost.

In 1985, the Department of Education submitted its seventh annual report to the Congress on special education services. In part it states:

> "Studies of the effectiveness of preschool education for the handicapped have demonstrated beyond doubt the economic and educational benefits of programs for young handicapped children. In addition, the studies have shown that the earlier intervention is started, the greater is the ultimate dollar savings and the higher is the rate of educational attainment by these handicapped children."

In authorizing a new subpart under the EHA, Congress will create the impetus for universal access to preschool programs for all children with handicaps.

The parenting of our daughter, Wendy, has been filled with hope and pride in her accomplishments. This is due in no small part to the fact that my wife, Kathy, and I took it upon ourselves to challenge the system and receive preschool programming. For years we have fought the stereotype that "nothing can be done" or "that she will grow out of it." Children with autism and other handicaps cannot wait while we debate the "cost effectiveness" of their need for preschool education.

Ten years of progress since the passage of P.L. 94-142 should be continued and expanded. Yes, there will be an increase in costs to carry out this mandate, but the financial cost of not delivering the needed services in the long run will be even greater. Further, the savings in human costs are immeasureable because early intervention prevents a multitude of problems later in the lives of children with autism and their families.

Thank you for the opportunity to share my daughter's story and testify before the Subcommittee today.

Mr. WILLIAMS. Ms. Ann Bardwell is with the Kentucky State Board of Education and is here representing the National Association of State Boards of Education.

TESTIMONY OF ANN BARDWELL, NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION

Ms. BARDWELL. Thank you, Mr. Chairman, members of the committee. I'm Ann Bardwell. I'm a member of the Kentucky State Board of Education, and I am Vice President of the National Association for State Boards of Education. I also come wearing some other hats over time that I'd like to share with you, which I think help to add to my concern for this issue.

I was on the faculty of the Niesonger Center for Developmental Disabilities, which is a university affiliated facility at the Ohio State University, for seven years. I was a Director of one of the first twenty-six projects HSEEP and developed an infant intervention program for infants with developmental delay.

Currently, I'm the Executive Director of a District Health Department where we believe prevention is what it's all about. So, therefore, I come to you to discuss the proposed legislation with you.

NASBE, as you know, is a private, nonprofit organization of over 600 State education policymakers from across the country. Our Association has historically held a strong commitment to the education of children with handicapping conditions.

We've watched the development of S. 2294, the Education of the Handicapped Amendments in 1986 with interest and support. Members of our Governmental Affairs Committee have reviewed the legislation and represent states which currently provide services to preschool handicapped children, including Connecticut, Illinois, Michigan and New Jersey.

Let me begin by saying that NASBE supports the principles of subpart 1 of S. 2294 to provide services for all children with handicapping conditions between the ages of 3 and 5. But I'd like to address two issues with relationship to that subpart, one, the timing of implementation and funding.

Over the last several years, States have shown a willingness to provide services for the 3 to 5 population. Twenty-three States have or are phasing in mandated services for 3 year old children with handicaps. Sixteen others provide services for 4 or 5 year olds.

These figures, which are reported to the United States Department of Education, do not reflect the total scope of services which you and I all know are out there that are being supported by public and private agencies.

With adequate lead time, I believe States can examine the variety of successful models, can do some planning and development, that many more States would be able to effectively serve the preschool population that is defined.

We recommend, therefore, a start-up date of September 1990 as the deadline for implementation, if the legislation is enacted this year. Certainly, that will give States an opportunity to coordinate the new program with the start of the new school year.

The second issue I'd like to raise has to do with funding. We've all talked about fiscal reality, and I'm not going to overburden you with the things that have been said already this morning. But, certainly, we know that we've never had full authorization for 94-142 yet. We know that we proposed a 40 percent initially. Currently, we all know that it's about 9 percent.

We have concerns that the $100 million each year in this new initiative will not begin to satisfy the financial need. I think we've said that many times. So I won't belabor that.

We've also heard that educational reform is taking place in our States, and it is; and we're doing exciting things. But we also know that resources are being stretched, often at the expense of other services, and we are concerned about that.

With respect to subpart 2, we have some real concerns about the 94-142 model to serve the children between the ages of birth and 2. The model establishes schools as the primary providers of services to children with handicaps and concentrates the legal and fiscal responsibility for these students in the public schools.

We all know that services to infants and toddlers require more direct attention to the needs of parents, and may need to operate through a system where schools are a partner. We've heard talk about interdisciplinary programs today. But they cannot be the sole provider of that service.

We have models going in some of our States, in particular, the South, in which South Carolina has a coordinating council for services to children in early childhood development. Kentucky's General Assembly just required the establishment of such a program to integrate and coordinate services to preschool children.

Policymakers and the public are looking at us. We demand a great deal from our schools. We hold them accountable for the education and wellbeing of our children, and we need to let them do what they do best.

Therefore, the National Association of State Boards of Education believes that perhaps that section of Senate 2294 does not go far enough in dealing with the birth to 2 population.

We believe that these children could and should be incorporated into an early childhood intervention initiative under separate legislation. We believe that a small segment of the children are addressed in Senate 2294, those which can be readily identified, those who have severe and profound handicapping conditions.

We've heard today, and I support again, there are the number of infants and toddlers at risk, whether it's environmental or biological risk, those who have low birth weight, those who come from children of drug and alcohol dependent mothers, those that we see in our Health Department who come from adolescent pregnancies, that many of these children are at risk; and they are not identified as handicapped—we've just heard the story—at birth. But they are at risk.

The legislation that we talk about for infants, 0 to 2, needs to be broad enough to provide the services that diagnose children, as well as those who are at high risk for special intervention services in the future.

We believe that the following point should be made with respect to this new initiative. We know that one of the basic needs of the parents of babies who are at risk is a link to a knowledge environment about child development and rearing. State Board members feel that an early intervention program from birth to two should include the development of improved identification procedures, a child advocacy component, parent training, and certainly the training of early childhood professionals.

The first contact a parent has with the birth of a child is with health care providers. These professionals are trained to identify high risk children at that stage, and they can set into process a movement where parents can be directed to the most appropriate resources.

The professionals can develop programs to assist parents to use infant stimulation techniques, to mitigate some of the adverse consequences of the conditions creating the risk. Frequently, parents of high risk infants have difficulty receiving guidance about their potential disability, the prognosis and the treatment. There are models available, though, that can be implemented.

Knowledgeable people who can help establish an ongoing relationship with parents is sorely needed. We believe that section 624 of the bill, the proposed early intervention council, could be incorporated into the early intervention legislation we're suggesting and retain responsibility similar to those outlined in Senate 2294.

We do encourage you, however, if you consider our recommendation, that a State Board member be acquired to be a member of that council, because we are the ultimate recipient of children, whether they are identified at infancy or whether they are not identified until they're 3, 4, or 5, because we do have that ultimate responsibility.

This is true with both in the council in South Carolina and our council in Kentucky.

The issue of providing educational services for children with handicaps is one that has consumed enormous time and thought on the part of State Board members across the country. We are committed to serving all children. We fear that services that are inadequate, that are not based upon research and may be premature, might do more harm than good in that they would lead to believe that we have an appropriate solution to a problem.

I urge you to consider the alternatives we have proposed. I want to add my commendation to the committee for its concern with the early educational needs of children with handicaps. It's wonderful for those of us who have been advocating for these programs for a long—so long, to know that there are people who share our concern who are making the laws of this nation.

I thank you for giving me an opportunity to meet with you this morning, and extend my personal help and that of our Association any way we can as you move forward.

Thank you.

Mr. WILLIAMS. Thank you very much.

[The prepared statement of Dr. Ann Bardwell follows:]

TESTIMONY
ON
THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

BY

DR. ANN BARDWELL

FOR

THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION

BEFORE THE SUBCOMMITTEE ON
SELECT EDUCATION

JULY 24, 1986

GOOD MORNING MR. CHAIRMAN, MEMBERS OF THE COMMITTEE. I AM DR. ANN BARDWELL. I AM A MEMBER OF THE KENTUCKY STATE BOARD OF EDUCATION AND VICE-PRESIDENT OF THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION. NASBE IS A PRIVATE, NONPROFIT ORGANIZATION OF OVER 600 STATE EDUCATION POLICYMAKERS FROM ACROSS THE COUNTRY.

MR. CHAIRMAN, OUR MEMBERS HAVE HISTORICALLY HELD A STRONG COMMITMENT TO THE EDUCATION OF HANDICAPPED CHILDREN. NASBE HAS WATCHED THE DEVELOPMENT OF S. 2294, THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986 WITH GREAT INTEREST AND SUPPORT. A NUMBER OF THE MEMBERS OF THE NASBE GOVERNMENTAL AFFAIRS COMMITTEE WHICH INITIALLY REVIEWED THIS LEGISLATION, REPRESENT STATES WHICH CURRENTLY PROVIDE SERVICES TO PRESCHOOL HANDICAPPED CHILDREN, NAMELY CONNECTICUT, ILLINOIS, MICHIGAN AND NEW JERSEY.

LET ME BEGIN BY SAYING THAT NASBE SUPPORTS THE PRINCIPLES OF SUBPART 1 OF S. 2294 TO PROVIDE SERVICES FOR ALL HANDICAPPED CHILDREN AGES 3 TO 5. WE WOULD LIKE TO ADDRESS TWO ISSUES WITH RESPECT TO THIS SUBPART: TIMING OF IMPLEMENTATION AND FUNDING. OVER THE LAST SEVERAL YEARS, STATES HAVE SHOWN A WILLINGNESS TO PROVIDE SERVICES TO THE AGE 3 TO 5 POPULATION. 23 STATES HAVE OR ARE PHASING IN MANDATED SERVICES FOR 3 YEAR OLD HANDICAPPED CHILDREN. 16 OTHERS PROVIDE SERVICES FOR 4 OR 5 YEAR OLDS. WITH ADEQUATE LEAD TIME FOR STATES TO EXAMINE SUCCESSFUL MODELS AND CONDUCT PLANNING AND DEVELOPMENT, MANY MORE STATES SHOULD BE ABLE TO EFFECTIVELY SERVE THIS PRESCHOOL POPULATION. WE WOULD RECOMMEND SEPTEMBER 1, 1990 AS THE DEADLINE FOR IMPLEMENTATION IF THE LEGISLATION IS ENACTED THIS YEAR. THIS WILL ENABLE STATES TO COORDINATE THE NEW PROGRAM WITH THE START OF THE NEW SCHOOL YEAR.

THE SECOND ISSUE WE WOULD RAISE REGARDING SUBPART 1 CONCERNS FUNDING. THE FISCAL REALITY THAT WE FACE WHEN WE COMPARE THE APPROPRIATIONS LEVEL OF THE EDUCATION FOR ALL HANDICAPPED CHILDREN ACT WITH THE NUMBER OF CHILDREN IN NEED OF SERVICES COMPELS US TO ENCOURAGE A HIGHER APPROPRIATION THAN IS CALLED FOR IN THE BILL. AS YOU KNOW, IN THE ORIGINAL AUTHORIZING LEGISLATION, CONGRESS COMMITTED TO PROVIDING FOR 40% OF THE NATIONAL PER PUPIL EXPENDITURE FOR HANDICAPPED CHILDREN. WE HAVE NEVER COME CLOSE TO THAT FIGURE. WE HAVE CONCERNS THAT $100 MILLION PER YEAR IN EACH NEW INITIATIVE RECOMMENDED IN S. 2294 WILL NOT BEGIN TO SATISFY THE FINANCIAL NEED OF EXPANDING THOSE SERVICES, COMPOUNDING THE FISCAL BURDEN ALREADY EXPERIENCED BY STATES.

WITH RESPECT TO SUBPART 2, WE HAVE CONCERNS ABOUT UTILIZING THE 94-142 MODEL TO SERVE CHILDREN BETWEEN THE AGES OF BIRTH AND 2. THIS MODEL ESTABLISHES SCHOOLS AS THE PRIMARY PROVIDERS OF SERVICES TO HANDICAPPED CHILDREN AND CONCENTRATES LEGAL AND FISCAL RESPONSIBILITY FOR THESE STUDENTS IN THE PUBLIC SCHOOLS. WE BELIEVE SERVICES TO INFANTS REQUIRE MORE DIRECT ATTENTION TO THE NEEDS OF PARENTS, AND SHOULD OPERATE THROUGH A SYSTEM WHERE SCHOOLS ARE A PARTNER BUT NOT SOLE PROVIDER OF SERVICE.

POLICYMAKERS AND THE PUBLIC AT LARGE ARE CONSTANTLY EVALUATING PUBLIC SCHOOLS AND THEIR CAPABILITIES. WE DEMAND A GREAT DEAL FROM OUR SCHOOLS. WE HOLD THEM ACCOUNTABLE FOR THE EDUCATION AND WELL-BEING OF OUR CHILDREN. WE SHOULD LET THEM DO WHAT THEY DO BEST.

ON THE OTHER HAND, HOWEVER, WE BELIEVE THAT S. 2294 DOES NOT GO FAR ENOUGH IN DEALING WITH THE BIRTH TO 2 POPULATION. IT FOCUSES ON A SMALL SEGMENT OF THOSE CHILDREN, THOSE THAT CAN BE READILY IDENTIFIED -- THE SEVERELY AND PROFOUNDLY HANDICAPPED. A NUMBER OF OTHER AT RISK INFANTS, FOR EXAMPLE, LOW BIRTH WEIGHT CHILDREN, CHILDREN OF DRUG AND ALCOHOL DEPENDENT MOTHERS AND CHILDREN OF TEENAGE MOTHERS GO UNSERVED UNDER THIS LEGISLATION. RESEARCH INDICATES THAT MANY OF THESE CHILDREN, NOT NECESSARILY IDENTIFIED AS HANDICAPPED DURING THEIR INFANCY, MAY EVENTUALLY NEED SPECIAL EDUCATION.

WE BELIEVE THAT THESE CHILDREN COULD AND SHOULD BE INCORPORATED INTO AN EARLY CHILDHOOD INTERVENTION INITIATIVE UNDER SEPARATE LEGISLATION. THAT LEGISLATION SHOULD BE BROAD BASED AND PROVIDE SERVICES FOR THE READILY DIAGNOSED PHYSICALLY AND MENTALLY DISABLED CHILDREN, AS WELL AS THOSE AT HIGH RISK FOR SPECIAL EDUCATION IN THE FUTURE.

WE BELIEVE THE FOLLOWING POINTS SHOULD BE MADE WITH RESPECT TO THIS NEW INITIATIVE. WE KNOW THAT ONE OF THE BASIC NEEDS OF THE PARENTS OF HANDICAPPED AND AT RISK BABIES IS A LINK TO A KNOWLEDGE BASED ENVIRONMENT ABOUT CHILD DEVELOPMENT AND REARING. STATE BOARD MEMBERS FEEL THAT AN EARLY INTERVENTION PROGRAM FOR CHILDREN FROM BIRTH TO AGE 2 SHOULD INCLUDE: (1) THE DEVELOPMENT OF IMPROVED IDENTIFICATION PROCEDURES, (2) A CHILD ADVOCACY COMPONENT, (3) PARENT TRAINING AND (4) TRAINING OF EARLY CHILDHOOD PROFESSIONALS.

THE FIRST CONTACT A PARENT HAS AT THE BIRTH OF A CHILD IS WITH HEALTH CARE PROVIDERS. THESE PROFESSIONALS, TRAINED TO IDENTIFY HIGH RISK CHILDREN AT THAT STAGE, COULD SET A PROCESS INTO MOTION THAT DIRECTS PARENTS TO THE MOST APPROPRIATE RESOURCES FOR THEIR CHILD. IN ADDITION, A PRACTITIONER WHO HAS INITIAL CONTACT WITH PARENTS AT THE BIRTH OF THEIR CHILD COULD BE TRAINED TO CONTACT AN ADVOCATE TO WORK WITH THE PARENTS OF THOSE CHILDREN.

FURTHER, THESE PROFESSIONALS COULD DEVELOP PROGRAMS TO ASSIST PARENTS TO USE INFANT STIMULATION TECHNIQUES TO MITIGATE SOME OF THE ADVERSE CONSEQUENCES OF THE CONDITIONS CREATING RISK FOR THEIR CHILD'S NORMAL DEVELOPMENT. FREQUENTLY, PARENTS OF HIGH RISK INFANTS HAVE DIFFICULTY RECEIVING GUIDANCE ABOUT THE POTENTIAL DISABILITY, PROGNOSIS AND APPROPRIATE TREATMENT FOR THEIR INFANTS. A KNOWLEDGEABLE LIAISON PERSON WHO WOULD ESTABLISH AN ON-GOING RELATIONSHIP WITH PARENTS AND WITH SERVICE PROVIDERS WOULD SUBSTANTIALLY REDUCE THE ANGUISH AND CONFUSION OF THESE PARENTS AND ENSURE THAT EVERY CHILD RECEIVES APPROPRIATE SERVICES. THE SCHOOLS COULD BE USED AS THE SITE FOR PARENT TRAINING CENTERS OR AS THE BROKER OF THE TRAINING PROCESS.

WE BELIEVE THAT SECTION 624 OF THE BILL, THE PROPOSED EARLY INTERVENTION COUNCIL COULD BE INCORPORATED INTO THE EARLY INTERVENTION LEGISLATION WE ARE SUGGESTING AND RETAIN RESPONSIBILITIES SIMILAR TO THOSE OUTLINED IN s. 2294. I WOULD ENCOURAGE YOU, HOWEVER TO INCLUDE A STATE BOARD MEMBER ON THIS COUNCIL. MOST OF THESE CHILDREN WE ARE DISCUSSING WILL EVENTUALLY ENTER INTO THE PUBLIC SCHOOL SYSTEM AND STATE BOARD MEMBERS HAVE THE ULTIMATE RESPONSIBILITY FOR THE POLICIES WHICH AFFECT THESE CHILDREN. THEY SHOULD BE AN ACTIVE PART OF THE COUNCIL.

THE ISSUE OF PROVIDING EDUCATIONAL SERVICES FOR HANDICAPPED CHILDREN IS ONE THAT HAS CONSUMED ENORMOUS TIME AND THOUGHT ON THE PART OF STATE BOARD MEMBERS AROUND THE COUNTRY. WE ARE COMMITTED TO SERVING ALL CHILDREN. HOWEVER, WE FEAR THAT SERVICES THAT ARE INADEQUATE, NOT BASED UPON SOLID RESEARCH, AND PREMATURE MIGHT DO MORE HARM THAN GOOD IN THAT THEY WOLD LEAD TO BELIEVE THAT WE HAVE AN APPROPRIATE SOLUTION TO A PROBLEM.

I RESPECTFULLY URGE THE COMMITTEE TO CONSIDER THE ALTERNATIVES WE HAVE PROPOSED.

I WOULD LIKE TO COMMEND THIS COMMITTEE FOR ITS CONCERN WITH THE EARLY EDUCATIONAL NEEDS OF HANDICAPPED CHILDREN AND I THANK YOU FOR GIVING ME THE OPPORTUNITY TO TALK TO YOU THIS MORNING. NASBE AND STATE BOARD MEMBERS LOOK FORWARD TO WORKING WITH YOU THIS AND OTHER ISSUES.

Mr. WILLIAMS. Our final witness is Ms. Carmen Taylor who is a fellow Montanan, and I want the other witnesses to note that we left our fellow Montanan until those of you who aren't from Montana had finished.

She's from the Flathead Reservation in Montana, and has for the past 3 years been the Program Director for the National Indian School Boards Association. It's a pleasure to see you again, and we're delighted you're with us.

I know you have a plane to catch within the hour. So you may proceed. We'll go right to you for questions when you finish and, hopefully, get you on your plane in time.

TESTIMONY OF CARMEN TAYLOR, NATIONAL INDIAN SCHOOL BOARDS ASSOCIATION

Ms. TAYLOR. Thank you. Mr. Chairman, members of the committee, I appreciate the opportunity to present our views regarding S. 2294 today, the Education of the Handicapped Amendments of 1986.

The National Indian School Board Association is an organization comprised of Indian controlled school boards which have provided advocacy, training and technical assistance to schools operated by the Bureau of Indian Affairs who are under contract with tribes. We've been in existence since 1982, and we represent potentially 181 schools in twenty-three States, 40,000-plus children, Indian children, in those schools.

Because the school boards in those systems derive their authorities from their various tribal governments, it is also very important for us to work closely with those tribal governments.

I'm going to present my remarks today within the context of the working government to government relationship between tribal governments and the primary agencies which those tribes relate to.

With respect to S. 2294 and Indian children, the following views and concerns are being presented:

Currently, under the Act the Secretary of Education is authorized to make payments to the Secretary of Interior for the education of handicapped children served by these schools that I spoke of this afternoon. In order to receive these funds, the Secretary of the Interior is required like the States to submit a State plan for approval by the Secretary of Education.

I would like to make a couple of recommendations with respect to the BIA State plan. My first recommendation is that it would be clearly required that BIA include services for 3 and 4 year olds in the plan that they submit. Prior to 1984, their plan to the Secretary of Education did include such language. At present, however, for the 1984 through 1986 period, the provision of services to 3 and 4 year olds in these schools is permissive.

In the 1985–86 school year, eighteen 3 year olds and fifty-four 4 year olds were served under the plan. Since the plan became permissive for serving 3 and 4 year olds, the number of children in this category have declined, the number of children actually served.

There is an additional concern for the BIA funded schools, and that is that, because they are located in twenty-three different

States, they are interested in achieving State accreditation into regional accreditation, the schools within that system are subject to various mandates.

We've got some schools in States where there are standards for 3 and 4 year old developmentally disabled students, and in order for them to obtain or retain State accreditation, that school will need to meet those requirements.

However, at this time the BIA does not provide the resources for that to happen, and it does place the accreditation for those schools within those existing States requiring those mandates—it places their accreditation in jeopardy.

In the BIA's own academic standards, there is a statement which reads as follows:

"In the States where additional minimum academic standards exist or are established, those State standards shall also apply."

So requiring the Bureau to include 3 and 4 year olds under their State plan would assist the schools that fall into this situation.

The second recommendation that we have relative to the State plan is that there be much more comprehensive consultation by tribes, parents and Indian school boards in the formulation and approval of the State plan. There really is very little of that taking place at this time.

In regard to early intervention for handicapped infants, we are very supportive of this program, because we know that there is a need that exists for services to Indian infants. Of concern to us, however, is that there is no specific mention of services to American Indian children and their specific needs.

An interagency approach between the Indian Health Services, BIA Social Services, BIA education and other available resources must be more clearly spelled out so that Indian infants do not get lost between the cracks while they're trying to determine who is responsible for providing services and paying for those services.

Although there are not any comprehensive statistics available, we do have some local information which provides an example of some of the need that exists. In the 1985-86 school year, the Southern Pueblo Agency in New Mexico did submit an application under BIA State plan to serve 43 developmentally delayed children ages birth through 4 years, and their parents, in a homebound type program.

These resources were matched through a State program. In addition, there were 22 children this past year on the waiting list.

I'd like to just bring up 3 important points about this already established program. Number one, there is already strong coordination between the local Indian Health Service providers, the BIA Social Services, BIA education, Head Start and the WIC program in that locale. And they coordinate in all areas, child find, service delivery, referral and follow-up.

The second point that I would like to make about this existing program is that homebound teachers provide a very strong instructional component for parents, recognizing the parent as being the primary teacher of the infant.

Third, that the infant eligible for this program, if they are determined to be developmentally delayed. No other categories are utilized in determining the eligibility, thus minimizing the labeling that goes on.

Just as an example of some referral that takes place, often it is the WIC people who have some knowledge of maybe the habits of the mother, and maybe because there is knowledge that the mother is addicted to alcohol or drugs, they are able to make an early referral. Oftentimes, these people make contact with the mother even before the child is born, and can establish that relationship even before birth.

We would recommend in the area of birth through 2 years inclusions of a strong family based component and a strong interagency approach, as I've spoken about here.

In one other location, we know that we have already identified this year 37 children birth through 5 years who will be entering the system at sometime or another. There have not been any formal diagnoses, but it is anticipated that these 37 children will require special educational services once they enter the BIA school system.

However, at present there are no resources to begin providing the necessary services for total diagnosis or to give them the attention that they need before they will enter.

The program at Southern Pueblos Agency in Albuquerque, I really think, should be looked at as a model for service delivery for Indian children birth through 2 years. It's an example of an ongoing program that's effectively delivering services, and there is good interagency cooperation.

We are in agreement with section 633 which authorizes an additional grant to address the needs of the native American children with handicaps. One grant would emphasize native Hawaiians, and an additional grant would be available for native Americans.

However, in other sections of the Act such as section 634, Research Innovation, Training and Dissemination Activities, section 641, Grants for Training Personnel, and Section 651, Research and Demonstration Projects, the newly added emphasis is on native Hawaiian handicapped children only.

Although we do not desire to remove this emphasis, we wish to reemphasize the varied travel, culture and traditions, which must be recognized and treated accordingly for the American Indians and Native American population.

Particularly in the area of training and recruitment, we have a difficult time recruiting for our schools. They are in very isolated reservation locations. Recruitment is difficult, and retention is even more difficult.

We would just like to ask that any setasides or special rules for native Hawaiians should not be at the expense of Indian tribes.

The various discretionary grants contained within the Act should be made clearly available to Indian tribes and institutions, and we would like to recommend that including Indian tribe within the definition of nonprofit would facilitate making clear their eligibility for the various discretionary grants outlined in the Act.

With the apparent broadening of the term Native American, it becomes increasingly important to clarify the definition of Indian in the definition section of this Act as well.

BIA's own mission statement talks about providing quality education opportunities from early childhood through life in accordance with the tribe's needs. We feel that with some modification to the Act, the stated mission could be more adequately carried out. There is already a vehicle for service delivery. The policies seem to be in place at the Bureau. Sometimes it's just a matter of encouraging them with a little more mandated language.

The BIA was directed to develop and publish early childhood regulations a couple of years ago at a time when their early childhood dollars were eliminated. They have put together a task force. They developed those regulations. We've not seen them since.

So we do think, even a couple of years ago, we were interested in trying to get the BIA to look at early childhood in a general way.

On behalf of the Association and our membership, I'd like to thank you for the opportunity to present our views and for your ongoing support in ensuring that Indian children receive quality education.

Mr. WILLIAMS. Thank you very much, Carmen. Let me ask you at least one quick question, and then have you on your way. As the BIA prepares their State plans, what consultation goes on between the tribes and the BIA of which you're aware?

Ms. TAYLOR. I think that the only legal requirement is what they do, and that is that they publish that the plan is available to be read at a certain specified location. There has never been any opportunity for any real dialogue or discussion about the plan.

I feel like it would be important to have some real outreach and try to get people in to discuss the plan.

Mr. WILLIAMS. Does PHS provide any grade school diagnostic services to children?

Ms. TAYLOR. Limited. At one time, up until about a year and a half ago, the Indian Health Service and the BIA had a cooperative or they cofunded a program called the Indian Children's Program. It was located in Albuquerque. The primary purpose initially was to provide national diagnostic services.

It became a regional program. IHS has now pulled all of their money out of the program saying that they're no longer in the business of providing direct service in that area, and there's a limited amount of money in that program now, only for BIA.

The problem with BIA being the only agency putting money in that is that it minimizes the population which can be served. It now is only ages 5 through 18, that the Indian Children's Program can serve, and only if they're in BIA schools. So we have a preschool population and a public school population of Indian children that are getting no services in that area at all.

Mr. WILLIAMS. Well, Carmen, thanks very much for being with us. We appreciate your taking the time to stop by and provide us with that testimony. Have a good trip.

[The prepared statement of Carmen Cornelius Taylor follows:]

STATEMENT OF THE
NATIONAL INDIAN SCHOOL BOARD ASSOCIATION
TO
THE SUBCOMMITTEE ON SELECT EDUCATION
OF
THE U.S. HOUSE OF REPRESENTATIVES
WITH RESPECT TO
S. 2294
THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

July 24, 1986

Presented by:

Carmen Cornelius Taylor
Program Director
National Indian School Board Ass'n.
P.O. Box 80008
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505/884-6820

Mr. Chairman and Members of the Subcommittee:

On behalf of the Board of Directors and the membership of National Indian School Board Association, I appreciate the opportunity to present our views regarding S. 2294, the Education of the Handicapped Amendments of 1986. The National Indian School Board Association is an organization comprised of Indian-controlled school boards which has provided advocacy, training, and technical assistance to BIA-operated and tribal contract schools since 1982. Of primary importance has been the facilitation of Indian local control and decision-making in accordance with Public Laws 93-638 and 95-561.

With respect to S. 2294 (the Act) and Indian children, the following views and concerns are presented for your consideration:

Under the Act, the Secretary of Education is authorized to make payments to the Secretary of Interior for the education of handicapped children served by elementary and secondary schools operated for Indian children by BIA or through tribal contract. In order to receive these funds, the Secretary of the Interior is required to submit a state plan for approval by the Secretary of Education. With respect to the BIA State Plan, the following recommendations are made:

1) Clearly require that BIA include services for 3-4 year olds in the plan they submit.

   At present, provision of services to 3 and 4-year olds is permissive. In the 1985-86 school year, 18 3-year olds and 54 4-year olds were served under the plan. Additionally, 225 5-year olds were served.

   A concern of some BIA-funded schools is that the state in which they are located may have standards for 3- and 4-year old Developmentally Disabled students and that,

> in order to obtain or retain state accreditation, the BIA school will need to meet those requirements. However, if BIA does not provide the financial resources, state accreditation of BIA-funded schools could be placed in jeopardy. BIA's published Minimum Academic Standards apply only to kindergarten through high school. However, Part 36.2(e) of those Standards states, "In the states where additional minimum academic standards exist or are established, those state standards shall also apply." Requiring BIA to include three- and four-year olds under the state plan would assist schools in this situation of being able to obtain or retain their state accreditation status.

Under Subpart 2 -- Early Intervention for Handicapped Infants, a new program is created for providing services to handicapped children birth through 2 years of age.

Of concern to us is that there is no specific mention of services to American Indian children and their specific needs. An inter-agency approach between Indian Health Service, BIA Social Services, BIA education, and other available resources must be more clearly mandated so that Indian infants do not get "lost between the cracks" while a determination is made who has responsibility for services. This is often the case.

Although there are not comprehensive statistics available, some localized information has been obtained. Southern Pueblos Agency in New Mexico has submitted an application under BIA's State Plan which served 43 Developmentally Delayed children, ages birth through 4 years, and their parents in a home bound type program. The resources from BIA are matched through a state program. Twenty-two children were on the waiting list this past year. Three important points about this already established program:

1) There is strong coordination with local Indian Health Services, BIA Social Services, and Head Start.
2) The Home Bound teachers provide a strong instructional component for parents -- recognizing the parent as having greater responsibility and being the primary teacher of the infant.
3) Infants are eligible for this program if they are determined to be "developmentally delayed". No other exceptional categories are utilized in determining eligibility.

In another location, Papago Agency in Arizona, BIA Special Educators -- in cooperation with IHS -- have identified 37 children, birth through 5 years, who will enter the BIA education system. Although there have not been formal diagnoses, it is anticipated that these 37 children will require special education services. Since IHS is the primary health provider for Indians, perhaps they need to be directed to provide pre-school diagnostic assessment and treatment

The program at Southern Pueblos Agency in Albuquerque could be looked at as a model for service delivery through interagency agreement for Indian children birth through 2 years.

We are in agreement with Sec. 633 authorizing an additional grant to address the needs of Native American children with handicaps. One grant would emphasize Native Hawaiians and an additional grant would be available for Native Americans. However, in other sections of the Act (sec. 634 -- Research, Innovation, Training and Dissemination Activities; Sec. 641 -- Grants for Training Personnel; and Sec. 651 -- Research and Demonstration Projects), the newly added emphasis is on native Hawaiian Handicapped children. Although we do not desire to remove this emphasis, we wish to re-emphasize the varied tribal cultures and traditions which must be recognized and treated accordingly for the American Indians/Native Americans. Child-rearing practices and acceptance of handicapping conditions are influenced by the cultures and value systems within each individuals tribe. Any set-asides or special rules for native Hawaiians should not be at the expense of Indian Tribes.

The various discretionary grants contained within the Act should be made clearly available to Indian Tribes and Institutions. Including "Indian Tribe" within the definition of non-profit would facilitate making clear their eligibility for the various discretionary grants.

With the apparent broadening of the term "native American", it becomes increasingly important to clarify the definition of "Indian" in the definitions section of the Act.

BIA's own Mission Statement as stated in CFR 25, Indian Education Policies, 32.3 is "The Mission of the BIA/Office of Indian Education Programs is to provide quality education opportunities from early childhood through life in accordance with the tribes' needs for cultural and economic well-being in keeping with the wide diversity of Indian tribes and Alaska Native villages as distinct cultural and governmental entities."

With some modification to S. 2294, the stated Mission can be more adequately carried out.

On behalf of the National Indian School Board Association, Thank you for the opportunity to submit our views and concerns and for your continued support in assuring that Indian children receive quality educational services and opportunities.

Mr. **Williams**. Mr. Helmick, you recommended the last dollar concept be included in the legislation and mandating the EHA funds could be used only after other funds, including, I assume, private insurance funds, have been exhausted. Would that provision prevent State Medicaid agencies or private insurance companies from withdrawing support for services which are mandated in the 0 to 2 provision under the law? Would it prevent them from doing that?

Mr. **Helmick**. Mr. Chairman, I'd like to defer the response to that, if you don't mind, to representatives from the Governmental Affairs Office of our American Speech-Language-Hearing Association. They're more attuned to the Medicare provisions.

Mr. Morgan Downey is with us.

Mr. **Williams**. Mr. Downey.

Mr. **Downey**. Thank you, Mr. Chairman. I'm Morgan Downey, Director of Governmental Affairs.

I think it would help. I think it's also an area that might need some further research. We have seen under 94-142 at present that Medicaid in many States and many private insurance companies have withdrawn coverage on the basis that services are available in schools.

We think the last dollar concept is essential. I'm not positively sure—I wouldn't want to represent to the committee I'm sure that that would totally prevent any retrenchment by Medicaid or private companies, but I think that would certainly get the concept across and would suggest it's an area for further exploration.

Mr. **Williams**. Thank you. We may be in touch with you about the ways to resolve that.

Also, Mr. Helmick, would you give me a rationale for making allocation decisions among States on the basis of census counts? I think you wanted to begin by using census counts, and you had an idea that the census formula should include a premium based on the number of handicapped children served. Would you expand on that?

Mr. **Helmick**. I think, as prepared in the testimony here, what we're concerned with in that issue—and again, perhaps Morgan can provide some more substantive data. We're concerned that the count program that is in effect is one that provides an opportunity for all children who fit the provisions of this legislation to, in fact, receive the services, particularly in those income areas where payment through private sectors may be somewhat limited. Morgan?

Mr. **Downey**. Well, I think our first concern is that the child count system as now used by 94-142 focuses on the primary handicapping condition, and it doesn't necessarily provide a good measurement for the extent of various conditions and the services they would require. So some alternative to that type of child count system, we would definitely support.

Mr. **Williams**. Ms. Bardwell, the legislation permits the governors, your Governor, to decide which agency in that State would be the lead agency, and it requires that each State establish an early intervention council. Do you agree—your Association agree, if you know—agree with the mechanism that's included in the Senate bill to facilitate interagency coordination, which I know you people believe is very important, and what should be the responsibilities of that interagency coordinating council, and how should it be chosen?

Ms. **Bardwell**. I think there are a couple of concerns. One of those, by leaving the decision at the Governor's discretion, it may well be because of the lead agency or the rest of the Handicapped Children's Act being with the State Departments of Education, that that would be the easiest way to go. I think that's a concern that you've heard expressed not only by us but by others.

I think one other thing in terms of the structuring of that coordinating council and that I would encourage, that we broadly define that council in terms of its not just being designed for children with handicapping conditions, but that it is a concern for child development, and that we have about, in the Kentucky legislation, approximately twenty-some-odd groups who are represented.

They include all of those agencies at the State level who are providing services to young children. They include Mental Health, Mental Retardation, Division of Health Services, Social Services, certainly the Department of Education. It includes Head Start. It includes parent organizations. It includes ARC groups. It includes the categorical agencies that we talked about here.

I think it's important that they get spelled out if in fact that it's going to be implemented across—within limits, certainly, to uniformity so that all of those concerns are represented on that interagency coordinating council.

It's tough when you talk about turf, when you talk about dollars; and, you know, we're worrying about that in Kentucky at the moment and, certainly—But it can work, but I think we have to—We're all need to be concerned about defining it so that it doesn't—people aren't left out by omission, not by commission.

Mr. **Williams**. I want you and the good members of the Association, the State Boards of Education, to understand that neither I nor this committee is without concern about the cost. When I referred earlier to the way that some Federal departments and agencies spend money, I did that with full recognition that this bill costs $100 million as it's envisioned in Federal money, but that it costs billions in State and local money. We understand that, and we don't take that lightly at all.

Your Association, the School Boards Association and the National Governors have now all come before us and said, careful of the money. You're talking billions of dollars here to our local people. We want you to know that we're very concerned about that as well.

Dr. Holmes, if you can leave your pal Wendy there for a minute, I need to have you do some testifying for us. Wendy is in good hands.

One of the concerns that's been expressed by other witnesses and other members of Congress have expressed this concern to me, is do we have adequate personnel, well educated, adequate personnel, available either in the schools or to the schools to provide the type of services that these children need? If they're not there, would they be there in sufficient numbers within thirty-six months or so?

Dr. **Holmes**. That's a very good question. I think currently available to the schools, we have more adequate personnel than we do currently have in the schools proper.

I think that what we've found in the past——

Mr. WILLIAMS. I'm sorry. Say that again for me. Than we have where?

Dr. HOLMES. Than we have in the schools proper, when we're talking about preschool intervention programming and so forth. I mean, outside of the educational systems, especially through State Departments of Human Services, because many of us who operate services that are eclectic in nature serving youngsters both under educational umbrellas as well as human services umbrellas recognize that the Departments of Human Services or whatever title relative to each State have responsibilities for infants with handicapping conditions at whatever level.

In terms of adequacy, it's like 94-142. When 94-142 was first passed, there was not adequate personnel in the educational systems to effectively deal with the youngsters that were now entering educational systems, but the law itself drove, if you will, the universities to offer high levels of training for personnel for the schools.

Currently, I think, with the passage, for example, in the State of New Jersey, with the passage in 1984 of a preschool handicap bill, now some of the State colleges are offering early childhood special education training, and they weren't offering it before the legislation was passed. They offered it after, which is typical of our system. I think the Federal Government many times drives through some of its legislation like 94-142—drives States vis a vis their State universities to offer advanced training courses.

So succinctly, currently we wouldn't have adequate personnel in the educational system. We do have—or the educational system would have access to adequate personnel.

Mr. WILLIAMS. Doctor, if several years ago, previous to Wendy's birth and those of other patients with whom you're familiar of her age—previous to their birth, if the Federal Government had said, Doctor, you must provide by Federal law all "necessary services" to this child until she reaches the age of 2, what would you have provided for her? What would have been the necessary services that you were required by law to provide, you and the school system?

Dr. HOLMES. Recognize that the programs that we offer—I basically have overselected my professional career on the problems of autism, and the problems of autism tend to be relatively unique relative to other developmental disabilities and, in fact, many times we find that some of the youngsters like Wendy don't even demonstrate symptoms until thirty-six months of age and so forth. But many, many of our young people do demonstrate the symptoms of autism from birth, and the kinds of services that we would offer, and we do offer, aside from our educational programming is intense parent training at the outset.

More often than not, what has happened in the past with autism is that parents have received counseling, therapeutic counseling, psycho-therapeutic counseling, because autism was felt to be caused by the parents, poor environmental conditions and so forth.

What we have done is, we've looked at the problems of autism and recognize it's a neurologically based disturbance of childhood and, as such, what we do is we work with the moms and dads to be better therapists or better educated, better teachers with their child in the home.

Mr. Watts mentioned that one of the things that is so important for moms and dads who have children like this is to know how to deal with them after school hours. So if we're dealing with an infant birth to 2, after school hours, if you will, and currently in the State of New Jersey is all the time. So we work closely with the moms and dads, giving them better tools for helping the child develop.

Mr. **Williams**. Next question is not meant to delve all into your costs, but rather—and I only say that, because I had asked you what you would do to provide necessary services to the age of 2. But what would be the average cost to a family, a yearly cost, to a family if you were, you and other doctors were billing them privately for those necessary services?

Mr. **Holmes**. I think, for the birth to 2 year olds, through the second year of age of a youngster, I as a professional—this is just my personal position—would feel that we wouldn't be looking at taking infants, newborns and infants, into our programs and taking them out of the house for a typical school day as we would with our 3 year olds.

I'm one of the few agencies in the Nation that feels that a preschooler 3 years of age really can benefit from a full day educational day, especially those with autism. But for infants, I wouldn't feel that that would be appropriate at all.

I think that the primary thrust for many birth to 2 year age youngsters would be in home types of services, working with the moms and dads, maybe some stimulation vis a vis some small group stimulation, and so forth; but on average it will be mostly in the home types of support services, which means the cost for those services on average would be far less than what you would find if the child were coming to either a public school or a private special education school.

You wouldn't, from my perspective again, see that you would have to have a one on one kind of educational program in the home. Rather, you would work closely with the moms and dads to give them better tools for interacting with their child and for helping that child reach his or her full potential.

So I would say that the cost would actually be less than maybe for a school age child.

Mr. **Williams**. Well, thanks very much.

Finally, Mr. and Mrs. Watts, we often hear from politicians, this campaign slogan—almost a campaign slogan, at least we hear it most often in campaign years. That is, if the government was just as good as the people in this country, then we'd have the kind of government that we need. I think both Democrat and Republican candidates for President have been quoted as saying that.

It seems to me that the kinds of effort that both of you have demonstrated in these last few years are among the most heroic and loving efforts that any Americans ever provide, and so in following that slogan, many of us believe that the government has to emulate as best it can through Federalism the type of concern and the type of efforts that you've expended on Wendy.

We should have done that long ago. We can afford to do it from the Federal level. We are hopeful that States and localities can also afford to do it. We do know that it's a significant up front cost, but as you indicated in your testimony we also understand that there's enormous savings in the long run to the treasuries in this society. But that speaks only to the economic matter.

The matter of humanity is also very important, and I'm hopeful that we, with this legislation, can bring all governments including school boards in this country to the type of efforts that you and your wife have made. We appreciate you being here and sharing your testimony with us, and bringing your daughters along.

Our thanks to all of you. Our next hearing will be on Tuesday the 29th which will be our final day of hearings planned on S. 2294. Again, my thanks to each of you.

[Whereupon, at 2:09 p.m., the subcommittee recessed, to reconvene on Tuesday, July 29, 1986.]

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

TUESDAY, JULY 29, 1986

House of Representatives,
Subcommittee on Select Education,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2261, Rayburn House Office Building, Hon. Pat Williams (chairman of the subcommittee) presiding.

Members present: Representatives Williams, Hayes, Jeffords, and Bartlett.

Staff present: S. Gray Garwood, staff director; Robert Silverstein, majority counsel; Colleen Thompson, clerk, and David Esquith, minority legislative associate.

Mr. **Williams**. The Subcommittee on Select Education today will hear continuing testimony on S. 2294, the Education of the Handicapped Amendments of 1986. We have heard from sixteen witnesses in our first two days of hearings, and we'll hear from an additional set of witnesses today.

I want to again say at the opening of this hearing that, at least in my own mind, the question is not whether we should move toward the establishment of early intervention, but rather, when we should do it and how we should do it.

We've heard almost every witness support, sometimes lukewarm, but nonetheless support almost unanimously for this legislation. In fact, I think I could say unanimously, for this legislation. But, likewise, there has been a near unanimous call for some change in the legislation.

One of the suggestions which has not gone beyond this subcommittee's notice is the suggestion that, while this legislation as it's now written, doesn't cost the Federal government an inordinate amount of money, it could stand to cost the States and localities a significant amount of money. That is based upon a CBO estimate which was earlier received by the Congress which indicated that between 265,000 to 600,000 children aged 3 to five are currently unserved in the United States. The cost estimate for the service then of all children ran $2.7 billion.

Yesterday, the Department of Education corrected that figure and told the staff that it estimated that rather than 600,000 unserved children the estimate is closer to 70,000 unserved children; and instead of $2.7 billion, the cost would be closer to $315 million.

We will later verify those figures but, if they are true, it will make, at least in this member's mind, a significant difference as to how swiftly we move this legislation.

Our first witness today is the Honorable George Miller who, among his other duties and leadership functions in this Congress, is that of the Chairman of the House Select Committee on Children, Youth and Families. George, we're delighted to have you with us here today and look forward to your testimony.

TESTIMONY OF HON. GEORGE MILLER, MEMBER OF CONGRESS FROM THE STATE OF CALIFORNIA: CHAIRMAN, HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

Mr. MILLER. Well, thank you. I want to thank you and the committee for taking this matter under consideration. I think that it's terribly important that we now turn our thoughts, after a decade of living with 94-142, that we turn our thoughts to taking this historic legislation that benefits the handicapped children of our Nation, those children who were, prior to this Act, excluded from mainstream education, were educated in closets, basements and institutions that would be unacceptable to any of us for our children, and in many instances receive no education at all, and as a result have not been able to fully participate in American society and, certainly, within the American economic system.

I think that we should all be very proud of what we did in 94-142, but I think we also ought to now step to the next plateau and make sure that we seek to intervene in the lives of those handicapped children at the earliest possible age so that we can realize the full benefits of this Act so that they can realize the full benefits of their life, and so that we can call upon the best of our educational experiences, our medical technology, our scientific efforts and bring them to bear on the abilities of these children for full participation.

I think that it was clear that the compromise that we made last time was essential in getting this law on the books, but I think when we look at it now, it's very clear that those preschoolers, those infants, must now be served. I think, at a time when those of us in the Congress of the United States and on the Select Committee on Children, Youth and Families have spent a great deal of time and effort on a bipartisan basis to see exactly what are the parameters of a wide policy of investment in America's children, one of the things that we clearly see time and again is that the investment at a very young age in children that are at risk has a very high payoff for our society and for those children and for their families.

I think it's very clear that in the case of handicapped children, that that is true; and it is something that we can no longer ignore, because we're now starting to see, after years of research and effort—we're starting to see the fact that the benefits are there, they are real, and they make a difference in these children's lives. And we cannot ignore those, as policymakers.

Let me give you a few examples of what has happened in the case of high quality early intervention. In the San Francisco Family Service Agency runs a fully mainstreamed childcare program for disabled and nondisabled infants, toddlers. The disabled infants, as a result, enter less costly mainstream preschool education at the age of 3.

The Department of Education's evaluation of handicapped early childhood programs shows that more than 50 percent of the participating children entered mainstream programs and more than two-thirds performed at average or above average range compared to their peers.

The Department of Education 1984 report said if intervention for handicapped infants is delayed until age 6, the educational costs to age 18 are $56,350. If intervention begins at birth, education costs are $37,000, a savings of some $19,000.

Colorado saves $1,560 per pupil in special education costs for those disabled children participating in model early intervention programs.

I think what is becoming clear is that those States that truly care and those communities that truly care about these children, on a test basis, on a pilot basis, small program basis, have shown us that, in fact, we can also have the kinds of budget savings that are essential as we consider the funding of this kind of legislation.

I think that also we must understand that we should consider this, because we're seeing a growing number of infants at risk because of maternal substance abuse where there's smoking, alcohol, cocaine or other drugs. I think we have got to prepare for that. It's a fact of life. We've got to prepare to try to stop it in material and child education. But if we don't, we've got to make sure that those children do not continue to be long term, lifetime victims of our failures to have a policy that intervenes on their behalf.

So I would just hope that, as you look to what the costs are—and, Mr. Chairman, I'm delighted to see that the Department of Education has reconsidered its estimates of both children that are not served and of the cost of serving those children. But I think what you will see here, that once again we have the potential because of the changes in our society over the last decade to dramatically affect the direction of these children's lives, of the wellbeing of their families, and their potential to participate in American society.

We have the ability to do it in a cost effective means, where policymakers such as the members of this committee, myself and others, will be able to go back to our constituents and in fact explain to them that the failure to do this, the failure to extend this service, in the long run is far more costly than to extend it.

The real savings of working with these children and with their families and providing those benefits and those services to them so that they can participate in a mainstreamed education experience and to get the best out of our educational system.

My testimony is no more complicated than that. We have been searching time and again throughout the Select Committee for these kinds of examples. Again, I say, on a bipartisan basis, what we have found is, there's a whole series of areas around early childhood intervention that just bring back to this Treasury far more money than we will ever expend on the provision of those services in terms of savings and in terms of these individuals' ability to participate in our society. I would hope that this committee will provide for the extension of education to the handicapped children as early as possible, because of these benefits.

[The prepared statement of Hon. George Miller follows:]

THE HONORABLE GEORGE MILLER
CHAIRMAN
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES
TESTIMONY BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION

July 29, 1986

Let me begin by commending Chairman Williams for calling these hearings on S. 2294, to expand P.L. 94-142, the Education for All Handicapped Children's Act, to serve disabled infants, and children ages 3 to 5. I appreciate having the opportunity to testify before the Committee on this important issue.

History of P.L. 94-142

More than ten years ago, when we passed P.L. 94-142 to assure that all disabled children had equal access to a free, appropriate public education, we took a truly historic action. And we have ample evidence that this landmark law has made a significant difference in the lives of millions of disabled children and their families.

We believed then, as we do now, that all children deserve to be educated together, regardless of their disability, and that this prevention approach is more humane and cost-effective than any other.

In 1973, at least one million handicapped children were excluded from school. Thousands of special education classes were being held in dismal conditions, in closets and basements. Many more children were hidden away in institutions, often with no educational services of any kind.

Today, because of P.L. 94-142, there are more than 4 million handicapped children receiving services along with other children in the public school system, and we have made significant strides toward eliminating discriminatory practices. While we know there is room for improvement, little of the progress to date could have been achieved without the law.

The development of P.L. 94-142 took several years, and much effort. But, while we can be proud of ourselves for that effort, we did not do enough. When that legislation was introduced, its authors, and I am proud to have been one of them, believed that the law's protections should extend at a minimum down to children three years old.

A Decade Later, Early Intervention is Still Needed

At that time, however, many feared extending the mandatory requirements for identifying and providing services to children down to age three. There were not enough systems in place for nonhandicapped preschoolers, some argued. Some raised the spectre of cost, while others argued that we lacked the knowledge to provide appropriate services to these youngsters.

Yet others contended that it was best to move ahead with the age groups schools were already serving, on the premise that, within a few years, they would extend those services downward.

Reluctantly, we compromised. We included preschool handicapped children in the law, but the mandate to states was "permissive."

Here we are, eleven years later. Programs for very young disabled children continue to be scarce, and in all too many instances, those providing services are inadequately trained. Yet the need is undeniable, and growing.

Only nineteen states mandate services for all three to five year olds. For at least some segment of this age group, a few additional states provide limited services.

But there may be as many as 1 million disabled preschoolers needing early intervention services, and only one-fourth that number receiving any.

In my own state of California, which has taken the lead in serving disabled children overall, only a small fraction of infants in need of services are being served by the public school system.

According to the California Ad Hoc Committee on Early Intervention, more than 15,000 infants requiring services are not being served.

According to the Northern California Infant Network, at best only 40%, and more likely 20%, of the 2% of infants who are developmentally disabled or at risk for disability were served in 1982.

In addition, recent hearings by the Select Committee on Children, Youth and Families suggest that there may be a growing number of infants who may not have a definitive diagnosis at birth, but who are still at-risk of developing a long-term, possibly severe disability, because of maternal substance abuse, including smoking, alcohol and drug use. In San Francisco recently, the director of Social Services pointed to the increase in children being born with drug addictions as contributing to the agency's burdens.

Early Intervention Works

There is no reason to doubt the continued need in the nation at large. Nor is there any reason to question the importance of identifying and providing services to preschool handicapped children, to assure assistance in early life, to prevent delay in their educational development.

The same is true regarding the importance of parental involvment in the provision of services to disabled preschoolers and infants. It is essential to children's success, and to the family's as well.

We can be even more sure now that early intervention works, as a considerable body of research has developed which shows that high quality early intervention, as early as the first month of an infant's life, can effectively reverse maladaptive patterns and promote healthy development.

Many programs have demonstrated their importance and effectiveness:

-- The Family Service Agency of San Francisco runs a full-day mainstreamed child care program for disabled and non-disabled infants and toddlers, including infants with medical disabilities who would not be served by any other program. The program has helped many infants with disabilities enter mainstreamed preschool settings at age 3.

-- The Children's Center in Salt Lake City offers intensive therapeutic intervention for preschoolers, often abused or at-risk of abuse, who have serious behavioral problems. 85% of the children are able to enter amd remain in regular classroom settings when they enter elementary school.

-- The 1982 Department of Education evaluation of 280 early education programs for handicapped children provided compelling evidence as well. 55% of the children who left these demonstration projects were placed in integrated settings with non-handicapped children and 67% of the children performed in the average and above average range in relation to their peers.

-- In Montogomery County, Maryland, a preschool serving non-disabled preschoolers and toddlers merged with two child care centers serving children with physical and mental disabilities, to successfully mainstream all the children ages 15 months to five years.

My own district of Contra Costa County, California serves as an example of what can be done to serve handicapped and at-risk infants and children when there is a commitment to do so:

-- Miller Centers East and West provide home and center-based early intervention and infant stimulation for about 100 developmentally delayed or disabled children ages 0-3, and support services for their families.

-- Several noteworthy programs, the Lynn Center, We Care, and Therapeutic Nurseries, and others, provide early intervention for infants and children at-risk of abuse or neglect, some of whom are disabled.

Early Intervention is Cost-Effective

What we have learned even more conclusively over the past decade is that providing services to young children is not only humane, but is much less expensive than alternative strategies.

-- The U.S. Department of Education, in its 1984 report to Congress, cited research that shows that if intervention for handicapped infants is delayed until age six, education costs to age 18 are estimated at $56,350. If intervention services begin at birth, education costs are estimated at $37,272. Total savings: $16,078 per child.

-- School districts in Colorado have saved $1,560 per pupil in special education costs because of a model early intervention program.

In short, early intervention programs work and save money. The earlier we identify and treat a disabled child, the more success can be achieved and the greater the return on our investment.

Seize the Moment

Timely consideration of S. 2294 offers this Committee and this Congress the opportunity to take another historic action, one long awaited, for handicapped young children and their families. We can dramatically ameliorate the daily struggles encountered by these families, which Lisbeth Vincent so eloquently described in testimony before the Select Committee on Children, Youth and Families:

> ...we are in a situation, as professionals, more than ever, we are capable of finding children early. We can screen, we can assess them, we can diagnose...We are keeping kids

alive, and then we are putting the family in five years of crisis. Five years of not being able to find therapeutic services. Five years of not being able to find integrated services. Five years of not being able to find family support services.

We ought not ask these families and these children to wait yet another decade. We have the knowledge; we know the earlier we can reach them, the better we can help all children, especially handicapped and at-risk children.. And we know that our efforts are cost-effective. The time is now. I urge you and your colleagues to move legislation providing services for handicapped preschoolers and infants this year.
disabled children, and the risk of child abuse and neglect even higher. While a range of family support services are necessary, early intervention services can mean the difference between a healthy family and a family in crisis.

Mr. WILLIAMS. Thank you very much. Because we both have formerly served on the Education and Labor Committee and the Budget Committee and today we share a service on the Budget Committee, I want to ask you a question with regard to the cost, and just get your opinion as to the mood in the House with regard to beginning a mandatory effort that would place a burden of cost on both the Federal treasury and the already buffeted state and local treasuries.

Whether that cost is $2.7 billion or $315 million, it is nonetheless an added cost to at least two public treasuries, and I'm wondering what your thoughts are about the likelihood of the Budget Committee, Appropriations Committee and, of course, the full House, accepting an additional mandatory appropriation in today's climate?

Mr. MILLER. Well, I don't think there's any question that the Congress will accept this program, because I think it follows again on the heels of what we've started to see in the Congress over the last—Oh, I would say, 2 or 2½ years—Well, let's just say 2 years, where in the Budget committee, again on a bipartisan basis, in the Select Committee on a bipartisan basis—and you can't go further to the left or further to the right in the Congress than you can on the Select Committee. But what there is is a hard recognition that early intervention with children that are at risk for whatever reason, that there is a payoff there, and we share a very common concern, a very common goal among all the members of these committees; and that is helping children.

I think, with the children's initiative in the Budget committee, that was a package of expenditures around related programs, but programs that had weathered the test in terms of cost benefit, that in fact each and every one of those efforts now, after years of study and following and monitoring, are proving to policymakers that an investment here was returning more than the dollar invested in terms of benefits to the Treasury.

It's not like these costs don't exist. Because we now quantify them when we decide that it's $300 million or it's a billion dollars, that's simply a gathering together of those costs. What we in fact see is that those costs are simply put off in some other segment of society. Whether they're internalized into the family without regard to their economic ability, or whether they're spread throughout the education system because they get these children later when they're more difficult to education, more disruptive to the classroom, and you get all of the problems that you've heard about a decade around 94-142, or whether we just end up with them on SSI or SSDI, those programs. These costs come back to us, because these children will not go away. These children are going to live in our society.

The only question for us is their contribution to our society and the quality of their life in our society. So the quantifying of those costs are very real, and I think what you will see—you'll hear from witnesses today and have already heard—that these efforts—There is an attempt, because of this recognition in local communities, to try and do this. But once again, we're only reaching a small percentage of the children in the families that are in need for this kind of service.

So it's not to suggest that only if you do this will you expend this money. That's not the question. The real thing is, if you do this and you do it right and you do it on a comprehensive basis, you will also be getting some benefit back, much of the benefit which you're not receiving today.

Mr. **Williams**. Well, thank you for taking the time to come here and speak.

Mr. **Miller**. I appreciate the opportunity, and again I want to thank the committee for discussing this issue, and look forward to seeing this bill on the floor.

Mr. **Williams**. Thank you very much.

Our first panel today is Carol Berman, Joan Sylvester and Michael Casserly.

Carol Berman is the Director of Development at the National Center for Clinical Infant Programs and is here representing that center. Ms. Berman, it's nice to see you today, and please proceed.

TESTIMONY OF CAROL BERMAN, DIRECTOR OF DEVELOPMENT, NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS

Ms. **Berman**. Thank you, Mr. Chairman and members of the subcommittee. Thank you for your invitation to testify.

The National Center for Clinical Infant Programs, which I'm representing, is a national, nonprofit organization established nine years ago to foster optimal health, mental health and development of infants, toddlers and their families through preventive, clinical approaches in the earliest years of life.

Mr. Chairman, it is conceivable that these amendments constitute one of the most important endeavors Congress may undertake for children in this session. There is no period of life when a human being is more vulnerable to damage nor more open to positive change than infancy.

It is important to look both to what child development researchers tell us about what infants need and the experiences of those who have been delivering services to these children and their families. During the past three years the National Center has worked with multiagency, multidisciplinary committees in 15 States through a grant awarded by the Maternal and Child Health Division.

Not surprisingly, many of the issues of greatest concern to the States who are already working with these populations are the same issues that are addressed in this legislation. I'll speak to them.

Included are the definition of the population to be served; the nature of services to be provided; the role of parents and other family members; how to integrate services and the relationship to other laws; and personnel qualifications and training.

With respect to the population to be served, the committee report from the Senate bill specifically excludes infants at risk because of environmental circumstances. We refer to environmental risk, I think, as the experiential circumstances that a child lives in, whether it's a substance abuse mother or retarded parent.

Mr. Chairman, it would be unfortunate if States denied services to potentially handicapped infants because the Federal definition was restrictive. Relatively few infants are born with established handicaps. More commonly, infants are at risk of disability because of a range of interacting biologic and environmental variables.

We know from research and from experience that the absence of a supportive, nurturing, caregiving environment can create or worsen disability in a disabled child. We also know that infants often defy diagnostic classification, partly because of the dynamic nature of growth and development.

There is little to be gained in stigmatizing a child or creating a self-fulfilling prophecy by making a diagnostic label a prerequisite for services. We suggest language such as "developmentally delayed or at risk of developmental delay" which would afford flexibility to States in defining the population to be served.

In the earliest years of life, services should be on a continuum that begins with early detection and that includes assessment and, where needed, treatment. States have been very creative in developing systems for identifying and tracking infants at risk through birth certificates, through birth defect registries, screening programs and common inter-agency reporting forms, for example.

States advise us, nonetheless, that they are still failing to identify and service high percentages of children who would benefit from intervention. Hence, follow-along is a very important component of early intervention services.

Treatment of children from birth through 2 appropriately and effectively means serving families. Programs need the flexibility to work with families in their homes in the evenings and in the context of parent support groups. Respite care and the supportive community home visitors may be as essential to good service as high technology intervention.

The service system includes a broad range of health, education and social service practitioners. It involves a very wide array of services under their umbrella. The services that are identified in the proposed bill under section 625 appear adequate, so long as they can be broadly interpreted.

For example, health services would include many of the activities performed by physicians, nurses, nutritionists and others. Family support services would include services such as parent to parent support.

A disabled or at risk infant cannot be helped in isolation from the family. The resources and needs of parents, siblings and sometimes caregivers or extended family members should be considered in the treatment plan, which should be developed jointly with parents.

The concept of an individualized family plan may be more appropriate than the individualized program plan, as the bill currently provides. The primary of parents in the lives of their children needs to be respected, and the wisdom of parents should help drive policy decisions at the State and local level.

The councils established in each State under the proposed legislation should include at least three parents.

I plan to submit for the record "Equals in This Partnership" in which parents speak to professionals about their experiences.

S. 2294 recognizes, laudably, that many agencies and organizations beside education agencies are required, in order to provide comprehensive services for young handicapped children. Indeed, under the current operating State planning grants in the States made possible by Public Law 98-199, many States have elected to place the lead for planning outside of the State education agency. The flexibility in selecting the lead agency that is available under the proposed legislation is entirely appropriate.

Because multiple funding streams often provide resources for children birth to 2, the Council specified in the Act should seek to assure that services are coordinated and comprehensive, rather than duplicative. We've heard of parents who had to go from one agency to another to get screening, only to find that the actual treatment services are not available, because everybody is doing screening.

Other examples of Federal programs—and I'm sure you're aware of all of them, but to name a few: Title V, Maternal and Child Health and Crippled Children's Services; Title XIX, Medicaid and EPSDT; Title XX under the Social Security Act; Head Start; Child Welfare; Developmental Disabilities Programs, the CASSP Program supported by the National Institute of Mental Health. All of these are programs that are currently having dollars flow into the states, and all of these dollars should continue to flow.

However, the burden should not rest solely with the SEA or the lead agency or the Council, provided workable cooperative agreements can be developed at the Federal, State and community level; and provided that the proposed legislation makes clear that these cooperating agencies have a voice through the Council in the comprehensive service system.

The point is that they all need a voice if they're going to continue to have their dollars flow. That's their greatest threat.

In terms of personnel qualifications, neither parents nor professionals are currently satisfied with training that professionals are receiving. Certification requirements within a discipline tend to be based on competencies that do not necessarily relate to work with infants, families or teens. Consequently, if personnel qualifications and other quality assurances are to be included in Federal law, State certification requirements are unlikely to supply appropriate assurances.

It may be better to require that States develop plans for competency based quality assurance and to stipulate that practitioners be assessed on knowledge of infant and toddler development and skills in working with infants and families and in working with interdisciplinary teams.

In summary, I've recommended flexibility in permitting States to define the population from birth to 2 to be served within the terms "developmentally delayed or at risk of developmental delay"; that services be viewed as a continuum ranging from screening to intervention by a wide range of practitioners; and that intervention occur where possible within the least restrictive environment; that the primacy of parents be recognized through use of the term "individualized family plan" and inclusion of parents on the policy making Council in each state; that multiple funding streams be maintained through cooperative agreements that give participating agencies decision making authority through the Council; and that personnel qualifications be addressed by States through quality assurance plans, and that competencies be based on knowledge and skills related to infant development, working with families, and team participation.

Thank you.

Mr. WILLIAMS. Thank you very much.

[The prepared statement of Carol Berman follows:]

NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS

TESTIMONY OF

CAROL BERMAN

NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS
733-15th STREET, N.W., SUITE 912
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202/347-0308

ON

THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986
(S.2294)

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION
COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

JULY 29, 1986

Mr. Chairman and Members of the Subcommittee:

I thank you for your invitation to testify. My name is Carol Berman. I coordinate a national project called Project Zero to Three for the National Center for Clinical Infant Programs, a national nonprofit organization established nine years ago to foster optimal health, mental health and development of infants, toddlers and their families through preventive, clinical approaches in the earliest years of life. Our organization was founded by clinicians, researchers and educators, who recognized that the care every child receives during infancy can have a critical impact on future functioning, that there are many divergent but related disciplines involved in infant care, and that comprehensive, integrated approaches are needed.

Mr. Chairman, it is conceivable that these amendments constitute one of the most important endeavors Congress may undertake for children in this session because:

- the impact of what you do with today's infants will be felt over the next 60-70 years - the life expectancy of many of these children.
- you may help to revise, stem or minimize to a great extent many of the long term effects of a handicapping condition. There is no period of life when a human being is more vulnerable to damage nor more open to positive change than infancy.

It is important to look both to what child development researchers tell us about what infants and toddlers need and the experiences of those who have been delivering services to these children and their families. During the past three years, NCCIP has worked with multiagency, multidisciplinary committees in fifteen states, through a grant funded by the Division of Maternal and Child Health. Under this grant we have helped states clarify and address issues related to serving disabled and at risk children from birth through two and their families.

Not surprisingly, many of the issues of greatest concern to practitioners and administrators already working with this population are the same issues addressed by the proposed legislation. These include:

- definition of the population to be served
- the nature of services to be provided
- involvement of parents and other family members
- integrated services and the relationship to other laws
- personnel qualifications and training

Population to be Served

Through its comittee report, the Senate bill specifically excludes infants at risk of disability because of environmental--i.e., experiential--circumstances. Some states, however, already provide services to infants whose environmental situations place them at risk of serious developmental delay or handicap. With a Federal definition of eligibility that is broad or flexible, the experiences of these states could be built upon. With a narrower definition, these states and others are likely to restrict their services to that population specified at the Federal level.
Mr. Chairman, it would be unfortunate if states denied services to potentially handicapped infants because the Federal definition of eligibility was restrictive. Relatively few infants are born with established handicaps. More commonly, infants are at risk of disability because of a range of interacting biologic and environmental variables. In the earliest years, these infants

need to be followed so that emerging problems can be identified and addressed. We know from research and experience that the absence of a supportive, nurturing caregiving environment can create or worsen disability in a vulnerable child. We also know that infants often defy diagnostic classification, partly because of the dynamic nature of growth and development. There is little to be gained in stigmatizing a child or creating a self-fulfilling prophecy by making a diagnostic label a prerequisite for services, particularly when the child's diagnosis may dramatically change. Language such as "developmentally delayed or at risk of developmental delay" would afford flexibility to states in defining the population they will address.

The Nature of the Services to be Provided

In the earliest years of life, services should be on a continuum that begins with early detection and that includes assessment and, where needed, treatment. New technologies and new knowledge enable us to help babies from before birth, at the moment of birth, and in the nursery. Increasing numbers of premature, low birthweight infants are surviving, thanks to advances in neonatology, and the intensive care nursery is an important target for early identification and monitoring of those graduates at high risk for handicaps. However, many high risk infants never require the neonatal intensive care unit because they are medically stable. States have been creative in developing systems for identifying and tracking infants at risk through birth certificates, birth defect registries, screening programs and common interagency reporting forms, for example. States advise us, nonetheless, that they are still failing to identify and serve high percentages of children who would benefit from intervention. Hence "follow-along" is an important component of early intervention services.

Treatment of children from birth through two appropriately and effectively means serving families. Programs need the flexibility to work with families in their homes in the evenings and in the context of parent-to-parent efforts. Respite care and the support of community home visitors may be as essential to good service as high technology interventions.

The service system includes a broad range of health, education, and social service practitioners, and involves a wide array of services under their umbrella. Services identified under Section 625 of the proposed legislation appear adequate, as long as they can be broadly interpreted. For example, health services would include many of the activities performed by physicians, nurses, nutritionists, and others; family support services would include services such as parent to parent support.

Parents and Other Family Members

A disabled or at risk infant cannot be helped in isolation from the family. The resources and needs of parents, siblings, and sometimes caregivers or extended family members should be considered in the treatment plan, which should be developed jointly with parents. The concept of an "individualized family plan" may be more appropriate than an "individualized program plan" as the bill currently provides. The primacy of parents in the lives of their children needs to be respected, and a fundamental principle on which service programs are built is recognition that the practitioner is less important in the life of the child than the family. Accordingly, not only are service programs planned with a strong family focus, the wisdom of parents should help drive policy decisions at the state and local level. Councils established in each state under the proposed legislation should include at least three parents. This minimum is suggested because, despite their competence and experience, some parents have indicated that in their service on commissions, they have questioned their own effectiveness, sensing they are outside the "power track" and greatly outnumbered by agency personnel.

Integrated Services and Relationship to Other Laws

S.2294 recognizes, laudably, that many agencies and organizations besides education agencies are required in order to provide comprehensive services for young handicapped children. Indeed, under the currently operating state planning grants made possible by P.L. 98-199, many states have elected to place the lead for planning outside of the State Education Agency. The flexibility in selecting the lead agency that is available under the proposed legislation is entirely appropriate. Some states have found that the education agency is best suited to take the lead because of the facilitated transition to school programs at school age. Other states have found that health personnel are more likely to have access and the first point of contact in the first two years. In other states, an independent council or a university based program has been selected as the grantee. Regardless of the lead, collaboration has been essential. An important role of the lead agency, in addition to helping to ensure effective cooperative agreements, is accountability with respect to entitlements. While it is not spelled out in the proposed legislation, we assume that the due process provisions would apply after the approved plan is implemented. This is an area that needs to be clarified.

Because multiple funding streams often provide resources for children 0-2, the Council specified in the Act should seek to assure that services are coordinated and comprehensive rather than duplicative. Parents should not have to go from agency to agency for repetitive screenings or assessments, only to find after multiple referrals that treatment services are not available. Collaborative use of resources by cooperating agencies can eliminate such redundancies and make a broader spectrum of services possible.

Other examples of Federal programs that relate to handicapped infants include Title V (MCH and CCS), Title XIX (Medicaid and EPSDT) and Title XX of the Social Security Act, Head Start, Child Welfare, and Developmental Disabilities programs. At the Federal level, the Child and Adolescent Service System Program (CASSP), concerned with emotional disturbances, has been launched in several states, supported by the National Institute of Mental Health. It is logical that dollars will continue to flow from these programs, so that the burden will not rest solely with the SEA or lead agency or council, provided workable cooperative agreements can be developed at the federal, state and community level, and provided the proposed legislation makes clear that these cooperating agencies have a voice through the Council in the comprehensive system of services. It is also important to address private insurance, as the bill wisely does, because some states have experienced denial of third party reimbursement because of the unwarranted expectation that a free and appropriate public education should release insurers from responsibility for covering services under the early intervention umbrella.

Personnel Qualifications and Training

Last year, NCCIP convened researchers, service providers, academicians, and parents from several states, government agencies and disciplines concerned with handicapped infants. The purpose of the meeting was to explore issues related to training of personnel. It was clear from the meeting that parents are not satisfied with the training professionals are currently receiving. They need specialized skills to work with infants who are handicapped or at risk, to counsel parents, and to work in collaboration with team members. Professionals at the meeting also were aware of shortcomings in their preservice training.

Certification requirements within a discipline tend to be based on competencies that do not necessarily relate to work with infants, families and teams. Consequently, if personnel qualifications and other quality assurances are to be included in federal law, state certification requirements are unlikely to supply appropriate assurances. It may be better to require that states develop plans for competency-based quality assurance, and to stipulate that practitioners be assessed on knowledge of infant and toddler development, and on skills in working with infants, families and interdisciplinary teams.

The personnel training programs made available through P.L. 94-142 have begun to have an impact. This committee is to be commended for its foresight in making possible inservice and preservice training for personnel across disciplines who work with infants.

In summary, I have recommended:

- flexibility in permitting states to define the population of children from birth through two to be served within the terms "developmentally delayed or at risk of developmental delay";
- that services be viewed as a continuum ranging from screening to intervention by a wide range of practitioners, and that intervention occur where possible within the least restrictive environment;
- that the primacy of parents be recognized through use of the term "individualized family plan" and inclusion of parents on the policymaking Council in each state.
- that multiple funding streams be maintained through cooperative agreements that give participating agencies decisionmaking authority through the Council;
- that personnel qualifications be addressed by states through quality assurance plans and that competencies be based on knowledge and skills related to infant development, working with families, and team participation.

Mr. **Williams**. Mr. Jeffords, would you like to introduce our next witness?

Mr. **Jeffords**. I most certainly would, Mr. Chairman. I'm very pleased to have with us today Joan Sylvester, who is the Director of the Vermont Association for Retarded Citizens, a coalition of some 25 advocacy groups. They have done a tremendous job in protecting the rights of our retarded citizens of Vermont.

Joan has been a very efficient and effective leader of that group.

Mr. **Williams**. We're delighted you're here and look forward to hearing your testimony.

TESTIMONY OF JOAN SYLVESTER, VERMONT ASSOCIATION FOR RETARDED CITIZENS

Ms. **Sylvester**. Thank you very much for inviting me to testify on this pending legislation, which we feel is really critical. As Congressman Jeffords said, I represent the Vermont Association. I also represent the Vermont Coalition of the Handicapped which is some 25 statewide advocacy organizations totaling a number of 6,000. So I have 6,000 voices behind me.

Just so that you know that there is no doubt from where we're coming, we really do urge the passage of a bill such as S. 2294. We feel at issue is equity and equality of all handicapped preschoolers, and offering them the educational opportunities.

As it is now, only nineteen States mandate early ed services for children from 3 to 5. Vermont has permissive legislation. So it does not take much imagination to know what happens. Families are really at the discretion of their school boards to determine whether their child will receive services or not.

We feel that there is enough research that demonstrates beyond doubt the effectiveness of early education. Many have testified prior to me, and I know you will hear more testimony today on how effective early education can be for children.

We join with others in really saying it's time to act on the results of this research and really afford equity for all handicapped preschoolers.

In Vermont, we are currently serving 76 percent of handicapped preschoolers ages 3 to 5, and only 13 percent of those birth through 2. We hope that your committee list does not impede the passage of this pending legislation.

You have a list of excellent questions, but you also have at your disposal excellent people and resources to help bring up some solutions for these questions.

Obviously, you can't do them in just the 7 minutes that you have to testify, but there are some really great people willing to work on this.

We concur with the testimony, especially offered by Martha Ziegler of the Federation of Children of Special Needs. In that, she talked about the use of the generic term developmentally delayed for ages 0 to 5, the emphasis on least restrictive environment as placement for handicapped preschoolers, and then the start-up dates. At least, have States do something for early intervention by September 1987, and having all States comply with fully from the 0 to 5 mandate by September 1989.

Likely, she mentioned the provisions of 94-142 should also apply to handicapped children ages 3 to 5.

I would just like to bring some positive stories and maybe really focus on the children who are being served, to give you a sense of what's happening in Vermont, which really demonstrates that early education in integrated settings does work.

I have to say that none of these stories could possibly be told without first commenting on the unrelenting and perservering advocacy of their parents. It takes carefuly planning, collaboration, meetings and lots and lots of support.

Mary Beth is four years old, and she attended a regular preschool program last year. She has a severe hearing impairment and communicates by cued speech. She was really fortunate to have early education services. A consultant teacher went into her home and gave helpful hints on how to make Mary Beth communicate more.

With the assistance of an interpreter, Mary Beth has learned to communicate with her classmates, and they, too, are learning how to sign. One day Mary Beth's friend came home and excitedly told her mother that her friend—she was learning "Indian" language with the use of hands. Mary Beth has phone calls. She has people stop by and, most of all, she is seen as a person, not as a disability. Next year she will be entering regular kindergarten with her classmates.

For Chris, who is 5 years old, early education services began with the visit of a home based coordinator. Chris was provided lots of stimulating learning experiences, and then he attended a regular preschool with special ed support services.

His parents have really marveled at the progress he has made. He is talking in complete sentences, and he, too, will be in a regular program next year. A telling sign of one of the gains is being invited to many of the birthday parties, and already he has been to three this year. By the way, Chris has Down syndrome.

I can personally attest to the value of education just through my niece Cathy who is nineteen years old now. She is currently in a regular high school program, has a summer part-time job. When she was born with Down syndrome the doctors, as usual, recommended that she be placed in an institution.

The family did not take her advice and, with the help of the first essential early ed program in Vermont, Cathy really did make tremendous gains. She eventually became an integral part of her regular school community. She's right now assistant manager of the cross-country team, attends school dances, and really enjoyed her junior year.

Her future really looks bright. She is thinking of going to the post-secondary college program at Trinity College, which is just beginning for adults who are disabled. She talks of having her own apartment.

So in a time when we all recognize the need to increase opportunities for people with disabilities to work, live independently and have friends, we really need to support public policy which provides individuals with the opportunity of a good beginning.

Children such as Mary Beth, Chris and Cathy have benefited from a good beginning.

My final story is about Amy. Last year, Amy was the first Down syndrome page who served in the legislature. She had this as a result of a combination of activities or factors. She had early education with her nonhandicapped friends. She had the active support of an unrelenting and perservering group of parents who have helped her throughout her educational career. She's now a freshman in regular high school, is on the basketball team, and is totally included in the life of her community.

She is really able to grow and has grown in confidence and competence: She is a role model for the many Mary Beths and Chrises who are following in her footsteps. Believe me, gentlemen, when special ed budget was voted on the Senate floor, Amy was the page. There was a unanimous vote for this special education budget. So, I tell you, we are training new Down syndrome children to become pages. We know that's the way to go.

Anyway——

Mr. WILLIAMS. You wouldn't be including these children as on-floor lobbyists?

Ms. SYLVESTER. Yes. But we do not register them. We do not register them.

Mr. WILLIAMS. You understand the rules prohibit that activity.

Ms. SYLVESTER. She was wonderful.

Mr. BARTLETT. Sounds as if we're doing a good job training some legislators also.

Ms. SYLVESTER. That's right. Absolutely right. As a matter of fact, one of the legislators who was the co-sponsor of S. 98 in 1970 was still there and made his speech. Amy is just wonderful, and there is a news article in the things that.I'm passing around.

Needless to say, wonderful things have happened for all our children when we've had the solid and perservering advocacy of parents. You can't do it without that.—backed by public policy such as 2294.

So we really urge Congress to put this policy in place this year, because we really feel that our Nation's children can't afford to wait much longer for equity for all handicapped preschoolers.

Thank you very much. I really appreciate coming here.

Mr. WILLIAMS. We appreciate your being here and your testimony.

[The prepared statement of Joan A. Sylvester follows:]

Testimony of

Vermont Association for Retarded Citizens
and the
Vermont Coalition of the Handicapped Education Committee

to

Subcommittee on Select Education
Committee on Education and Labor
U.S. House of Representatives

Regarding

Education of the Handicapped Amendments of 1986

July 29, 1986

Presented by:

Joan A. Sylvester
Executive Director
Vermont Association for Retarded Citizens
Champlain Mill #37
Winooski, VT 05404

Thank you for inviting me to testify on this pending legislation, which is so critical for handicapped children and their families. I am representing the Vermont Association for Retarded Citizens and the Vermont Coalition of the Handicapped Education Committee, of which I chair. The Coalition is an alliance of 25 statewide advocacy organizations representing various disabilities and numbering over 6,000 members. We endorse S.2294 and urge Congress to pass it this year!

My testimony will focus on two significant amendments; one which will mandate a free appropriate public education to all handicapped children from ages 3 to 5 and the other which encourages states to develop comprehensive planning for early intervention services for children from birth through 2. The heart of the matter is equality of educational opportunities for ALL handicapped preschoolers.

Presently, only 19 states mandate essential early education services for children ages 3 to 5. In Vermont, essential early education services are not mandated; they are permissible based upon funds available. It doesn't take much imagination to know how this permissive legislation affects children. There are some communities who will provide services and some who won't, which creates an inequity. We feel this is unacceptable.

Research demonstrates beyond doubt the effectiveness of preschool education for handicapped children. Studies have shown that when intervention begins early, the ultimate dollar savings are greater and the level of educational attainment is higher. Further research documents the benefits of educating children in the least restrictive environment; that is with their non-handicapped peers.

In Chittenden South School District in Vermont, an essential early education teacher has been doing follow-up studies of students who have "graduated" from her essential early education program. In the 12 years the program has served over 400 handicapped preschoolers; only ONE child has transitioned into a special education class. The rest have attended the school district's public kindergarten. By the time these same "graduates" entered the 5th grade, about 47% no longer required special education services.

In essence, we have gone beyond the point of demonstration. As a result of the wisdom of Congress who financed some of this early education research, we now know that essential early education works. **It's time to act on the results of this research and afford equity to all handicapped preschoolers.**

Equity of early education services was the highest priority as a result of a statewide needs assessment survey conducted by the Division of Special Education this year. Excerpts from that study are in the appendix. Also included are the childcount figures which show who is receiving services and who is not. Vermont is currently serving 76% of its estimated handicapped preschoolers ages 3 to 5. We are only serving 13% of those ages birth through 2.

One of the Committee's questions dealt with the 3 year phase in time.--Is it too long or short? If I am a parent in an area where there are no services, 3 years is way too long. If I am an administrator balancing budgets, 3 years may be acceptable. Clearly, all of us recognize this as a compromise. **We would, however, recommend that there be some minimal startup effort in early intervention for all states by September, 1987, and that all states be required to comply fully with the 0 to 5 mandate by September, 1989.**

Our current total budget for essential early education is 2.2 million dollars. An estimated two million in new dollars will be necessary to serve all children ages birth to five. Because Vermont has no mandate, the

Legislature has appropriated $50,000 for 1 new essential early education program the past 4 years. Given this track record and the estimated unmet needs, it will be 40 years before Vermont is serving all the eligible children!

We also concur with the testimony offered by Martha Ziegler of the Federation regarding the use of the generic term "developmentally delayed" for children ages 0 to 5. There is a great deal of literature that addresses the issue of labeling and its detramental effects on children. The intent is not to broaden the definition of handicapped children, but to avoid the problems associated with categorically labeling handicapped children. In Vermont, we are non-categorical for 3 to 5 year old children and it should be noted that as a result we are not serving an unusually large number of children, which is the fear sometimes when using that definition. **Furthermore, we recommend emphasis on the least restrictive environment.** This means attending programs with children the same age who are not handicapped.

I hope that the committee's questions do not become a stumbling block or do not impede the passage of this critical piece of legislation. Currently, there are too many families who rely on the discretion of schoolboards to determine whether or not their child will receive services. We know of many families who have personally pleaded with their local school board for early education services who have received no for an answer. One family requested assistance from the schoolboard for their four year old child who had Down syndrome and needed speech services, but were turned down. While in an adjacent town, the same situation occurred and the schoolboard voted YES. In the end, the first family decided to move to a different school district who provided early education serivces.

Because Vermont is a small, rural state, many of us personally know the families involved. It is heartbreaking to hear the stories of families whose children are in desperate need of services and it is equally heartbreaking to know that there are no solutions when you are dealing with an unresponsive system.

I would like to end with some positive stories which clearly demonstrate that early education works! None of these stories could be told without first commenting on the unrelenting and perservering advocacy of their parents. It takes careful planning, collaboration, meetings and **lots of support**!

Mary Beth is 4 years old and attended a regular preschool program last year. She has a severe hearing impairment and communicates via cued speech, which is a combination of sign and lip reading. Mary Beth was fortunate to have eary intervention services; a consultant teacher went to her home at 3 months to assist the family and give helpful hints. With the assistance of an interpreter, Mary Beth has learned to communicate with her classmates and they are learning sign. One day, Mary Beth's friend came home and excitedly told her mother that she was learning "Indian" language with her hands! Mary Beth has friends who call her on the phone and stop by her house. Above all, they see Mary Beth as a friend, not as a person with a disability. Next year, she will be going into regular kindergarten with her classmates.

For Chris, who is now 5 years old, early education services began with the visits of a home-based coordinator. The coordinator provided Chris with lots of stimulation and learning experiences. Chris then attended a regular preschool with special education support services. His parents marvel at the superb progress Chris has made in this integrated environment. He has many friends, is talking in complete sentences and will be in a regular program next year. The telling sign of "being one of the gang" is being invited to birthday parties. Already, Chris has been to three this year. Chris, by the way, has Down syndrome.

I can also personally attest to the value of essential early education services. My niece Cathy who is nineteen attends a regular high school and holds a part time job in the cafeteria at a medical center. When Cathy was born with Down syndrome the doctors recommended that she be placed in an institution. The family did not take their advice! With the help of the first essential early education program in Vermont, Cathy made tremendous gains. She eventually became an integral part of the regular school community and that has definitely made a difference. She is assistant manager of the cross country team; attends school dances and thoroughly enjoyed her junior year. Her future looks bright! She talks of going to a postsecondary college program just beginning for adults who are disabled and of having her own apartment.

In a time when we all recognize the need to increase opportunities for people with disabilites to work, live independently and have friends, we must support public policy which provides individuals with the opportunity of a good beginning. Children such as Mary Beth, Chris and Cathy have benefitted from a good beginning.

My final success story is about Amy. Two years ago, Amy served as a page in the Vermont Legislature. This was the first time an individual with Down syndrome had the opportunity to assist in the Legislature. A combination of factors enabled this to happen. Amy had early education with her non-handicapped friends and also has the unrelenting advocacy and strong support of her parents throughout her educational career. As a result, Amy has been able to grow in confidence and competence. She is a role model for the many "Amys" and "Chrises" who are following in her footsteps.

Wonderful things happen for all our children when we have the solid and perservering advocacy of parents, backed by public policy such as this one.

We urge Congress to put into place this policy this year. Our nation's children cannot afford to wait much longer!

Sunday, April 21, 1985 . . .

Ms. Angney Goes To Montpelier

By CHRIS LAVIN
Free Press Staff Writer

MONTPELIER — Sen. Thomas Crowley, D-Chittenden, tapped his pen three times on his desktop to get Amy Angney's attention. She sprang from her stool, and being careful not to walk in front of the speaker addressing the Vermont Senate, she arrived at Crowley's side.

The senator peered at her over his spectacles. He pointed to one note, gave her instructions, then handed her other papers. She took them from his hand, delivered one note to the president's desk and another to a senator across the room, and again took her place on the stool.

Amy, 15, is one of 18 pages chosen from among eighth grade students around the state to serve during a session of the Legislature. With deliveries in hand, she carries messages and other papers throughout the capitol, from one corner of the building to another in search of senators and representatives. Down's Syndrome has not prevented her from doing her job.

"I've never noticed any difference in her ability to serve the Legislature than anybody else," says Rep. John Murphy, D-Ludlow, who has become one of Amy's dearest friends. "The best thing about her is her smile."

Amy is not the first in her family to serve in Montpelier. Her grandfather, Allan Angney, was a legislator in the 1960s. Before he died, he talked to her for hours about state government and about the people there.

So when Amy entered the eighth grade, she wrote a letter to the sergeant-at-arms saying she wanted to apply to be a page, despite the fact she has Down's Syndrome. Down's Syndrome is a birth defect caused by an extra chromosome in the DNA. It causes mental retardation.

"I like my job," Amy says. "I deliver messages and do some other things, and I like the people."

Amy's curly brown hair bounces when she walks. She usually goes for a hamburger and some yogurt in the statehouse cafeteria. Amy grins with little encouragement, and will ask questions when she has them.

"Amy is our last of four. We don't expect anything less from her than we did with the others," says Alice Angney, Amy's mother and superintendent of Washington Central Supervisory Union. From learning social graces to doing her math homework, Amy has done everything her older sisters have done, growing up in their East Montpelier home.

The extra chromosome manifests itself in different ways, [illegible] physical traits such as a rounded head and narrow eyes.

"You do either have it or you don't," says Dr. David Stifler of Essex Junction. "Some people have more problems than others."

But why would Amy seem so "normal," when other children with Down's Syndrome seem to have a harder time grasping instructions and ideas?

"I think you're learning what I've been learning," Stifler says. "There are a lot of stereotypes we all have about a lot of things. It takes a while for us to learn, to relearn, about those stereotypes."

Doctors are learning that stimulating environments have a lot to do with the manifestation of Down's Syndrome in children. When Alice Angney gave birth to Amy 15 years ago, she made up her mind: "That day I said, 'She will be able to read and write.' "

The Angneys made Amy's education a family effort. They drove her to the E.M. Luse Center of the University of Vermont in Burlington three or five times a week for physical therapy and educational stimulation, and worked with her constantly at home.

"She met all the milestones," Alice Angney says, like rolling over with help and toilet training. "The only thing she took longer on was walking." Alice and Richard Angney worked with her daily, until she walked around the house by herself.

They held her back from starting kindergarten for one year. She has been in school, progressing one grade every year, ever since.

"We wanted her to have a peer group," Alice Angney says. It hasn't been easy for Amy to keep up with her classmates, as they graduated from year to year.

"She's a hard worker," Richard Angney said. Her parents have seen their daughter, even though she loves to be the first one in line, go to the back so she can watch how others do something before she has to try.

"There have been a lot of people who have believed in Amy," Alice Angney said. "The schools have been terrific."

The children in her class have been supportive too. One of her sixth grade friends, Jonathan, always asked her to dance at school dances, and picked her as the first member for his basketball team.

"He was a good friend," Amy says. Jonathan died two years ago of cancer.

Yet now she is making new friends in the Legislature who are gaining Amy's respect, as Jonathan did.

"It about threw me for a loop when I found out Amy had Down's Syndrome," Murphy said. "She doesn't act it. You'd never know it by the way she talks to you."

Amy cracks jokes with her family and friends, understanding sarcasm and laughing at herself. Once, when some food was left on the dinner table and Amy and her father both wanted it, they decided to divide the portion.

"Amy took most of it, more than half," Alice Angney recalls. "Richard said, 'Well, Amy, are you sure you have enough?' Amy barely stopped chewing long enough to say, 'Very funny.' "

Another time, riding to U-32 High School with her sister Krista, Amy complained about Krista's speeding.

"Hey, you can get out and walk if you want to," Krista replied. But Amy was right on top of her. "You're lucky to have me as a sister," Amy told her. They both laughed.

Amy does all the things others in her class do. She has shown horses in 4-H shows, plays basketball (and has made two baskets in two seasons) and even overcame her fear of swimming. She now dives off the high diving board.

"I'm brave," Amy says. "You have to be brave."

Amy hasn't decided what she wants to be when she grows up. She does know that she wants to go to college, and that "a career will come first, before a family."

For now, Amy is teaching people in the Statehouse just as much as she is learning about the government her grandfather talked of often.

"You should go in there and watch her in the Senate," says Reide Payne, sergeant at arms. "It would do your heart good."

Mr. WILLIAMS. Mike Casserly is Legislative and Research Associate with the Council of the Great City Schools. Mike, we're glad to have you here today, and please proceed.

TESTIMONY OF MICHAEL CASSERLY, THE COUNCIL OF THE GREAT CITY SCHOOLS

Mr. CASSERLY. Thank you, Mr. Chairman. There must be a one-liner here someplace about lobbyists. I'll come with it someplace along the line.

I thank you very much for this opportunity to testify before the subcommittee on the Educational of the Handicapped Amendments. I'd like to restrict my testimony this morning to the 3 to 5 service program mandated in the proposed bill.

Like many of my colleagues who have testified, the Council firmly supports the notion that early intervention in the lives of young people pays enormous dividends in the future. The evidence for this continues to be overwhelming for handicapped and non-handicapped children alike.

Unfortunately, our society has often failed to make this investment in large enough doses to assure and enhance the quality of life for subsequent generations.

Let me mention parenthetically, Mr. Chairman, that while I have no particular reason to doubt the Department of Education's new estimates on the costs and the number of children that would be eligible, I must say that if history is any guide, the Department of Education often has a bad habit of putting out numbers that are not based on reality; and I would urge the committee to take some additional estimates from additional sources on what the cost of the program might be.

The Council of Great City Schools, as you know, is proud of its longstanding support of and advocacy for children in our inner cities, for civil rights, and for the rights of the disenfranchised in our society, including those of handicapped children and their parents. We are also cognizant of the fact that until passage of Public Law 94-142 many public schools, including our own, were not as responsive to the needs of handicapped children as was appropriate.

We also recognize there was some distance to travel in that regard. Our most difficult task as the coalition of big city schools is meeting the needs of our unusually large concentrations of the poor, the handicapped, the limited English proficient, the hungry and the unemployed, and building our institutional capacities to do so, and to meet new challenges whenever society asks it of us.

The Council's endorsement of the concept of the proposed legislation is offered in that context. We strongly support meeting the needs of preschool handicapped children, and also believe that the passage of the proposed legislation, unfortunately, without the needs to implement it, would dupe the children we seek so desperately to serve.

While many of our school systems currently offer services to handicapped children aged 3 to 5, most have not done so on a comprehensive basis and would require large infusions of personnel, facilities, materials and other items to do the job that the new law would mandate.

We will be pleased to work tirelessly for passage of S. 2294 if we know the Federal Government is as serious in this commitment to the handicapped as it is asking us to be.

Mr. Chairman, we commend the committee for convening these hearings. The new mandates for serving aged three to five beg for considerably more study. Our first recommendation, in fact, is that the subcommittee continue these hearings by calling on witnesses from local school systems who would have to implement the law. We believe that local administrators and school boards ought to try to estimate what capacities they now have and what would be needed in order to serve the 3 to 5 age group.

This is not a recommendation that we make in order to stall off the passage of the legislation, but only to help the subcommittee in its consideration of the technicalities of the law.

The 37 school districts comprising our organization currently serve approximately 420,000 handicapped children at an annual cost of about $1.7 billion from all local, State and Federal sources. Approximately 11 percent of our total expenditures of $14.7 billion is devoted to special education, but individual school district expenditures for the handicapped range from a little over 6 percent in Dallas to a little over 22 percent in Tulsa, OK. Nearly 14 percent of our total full time teaching staff is employed to teach the handicapped; 44 percent of our part-time teaching force; 32 percent of our full-time teacher aides; and 31 percent of our part-time aides are in the business of special education.

Most of this capacity, however, is used for aged 5 and over. Early childhood programs, in fact, are a fairly recent development for most of our city school systems, many of whom did not even offer general kindergarten services until 10 to 15 years ago. In general, city school systems are probably further ahead in their capacity to deliver preschool services to the handicapped children, however, than they are to other kinds of children.

The proposed legislation, unfortunately, puts us in the very uncomfortable position of having to develop further our capacities in the preschool handicapped—for the preschool handicapped at the expense of other badly needed preschool services. What is desperately required here is a national agenda that will recognize the preschool needs of all of our children.

Still, the cities are operating preschool special education programs in many places on a limited and not comprehensive basis. Dallas, for instance, has been operating a 3 to 5 year old program since the passage of Public Law 94-142 in 1975. It serves about 400 children in 36 classrooms at slightly over $4,000 per child.

The new Texas mandate to serve 4 year olds in pre-K programs, although not exclusively for the handicapped, is expected to supply some additional dollars to the Dallas system, approximately $1.6 million, as I understand it, but also draw just additional children.

It is worth noting that the Texas law provides leeway for LEA's to apply for waivers or phase-ins when dollars or specially trained teachers are in short supply.

The Pittsburgh program, which is a voluntary one, serves about 150 to 170 3 to 5 year olds from a variety of State and Federal sources at approximately $3,400 per child. Services include diagnosis, speech therapy and others.

Students not served by the schools are served in larger numbers by the Pennsylvania Welfare Department through contracts with public and private agencies.

Boston, which is in a State that has mandated services, provides services for this same age group ranging from consultations to full day programs four days a week at a cost of approximately $7,000 per child.

These efforts and others, while not comprehensive, are being implemented as quickly as possible on either a voluntary basis or through State requirements as resources allow. Additional Federal requirements to serve 3 to 5 year olds will be difficult, although not impossible, for our school systems to meet, but made more difficult to meet if they do not have the capacity to do so. To develop the capacity on a short term basis will require either expenditure cutback in other worthy areas or revenue increases that will be difficult to realize.

Still, Mr. Chairman, we believe that this legislation is worthy and that children aged 3 to 5 are deserving of the services; and we will do all that we can to ensure that. To that end, the Council would like to make the following proposals to the subcommittee for consideration. You've heard a couple of these from previous witnesses.

The first is to modify current law or the current language in the bill to provide for entitlement benefits for all youngsters between birth and 5 years old, with the Federal portion set at least at 40 percent of entitlement.

We realize that there are some difficulties, both technically and budgetarily, with that proposal, but we are prepared to talk about it.

The second possible option might be to modify the current legislative proposal from one that builds the primary emphasis or program delivery around the public school systems and instead builds it and coordinates it around other Federal, State, and local programs that are already in existence, rather than trying to build up the capacity of local school districts to serve birth through 5 in an area where they haven't done so before.

The third general proposal is to try to coordinate services under this bill with efforts to reduce teenage pregnancy and efforts to reduce alcohol and drug abuse. I was glad to hear that Congressman George Miller made a similar proposal, and I think it's one worthy of considerable study and consideration by the subcommittee.

The fourth possible option would be to develop a series of local capacity building grants for LEA's if they are to be the lead agency in this delivery system for the first 3 years of the program in order for them to gear up for this kind of massive undertaking.

The fifth proposal, a simple one but probably not as acceptable to the handicapped community, would simply be to build up the funding for the preschool incentive grants to attract greater programming in the 3 to 5 area.

We have a number of other recommendations that we are exploring, and the Program Directors for Special Education in the city schools are taking a look at the legislation, and we hope to have further recommendations for the subcommittee in the future.

That concludes my testimony, and I'll be happy to try to answer any questions you may have.

Thank you very much.

[The prepared statement of Michael Casserly follows:]

Testimony

on

The Education of The Handicapped Amendments, S. 2294

before the

Subcommittee on Select Education

of the

Committee on Education and Labor

U.S. House of Representatives

Presented by

Michael Casserly
The Council of The Great City Schools

July 29, 1986

Washington, D.C.

Testimony on The Education of The Handicapped Amendments, S. 2294
Presented by the
Council of The Great City Schools

Mr. Chairman, my name is Michael Casserly, Senior Associate for Legislation and Research for The Council of The Great City Schools. I am pleased to have this opportunity to testify before this Subcommittee on the Education of the Handicapped Amendments.

Currently in its 30th year, the Council of The Great City Schools is a national organization comprised of 37 of the nation's largest inner-city public school systems. Our leadership is comprised of the superintendent and one Board of Education member from each city, making the Council the only education group so constituted and the only one whose membership and purpose is solely urban.

The Council's membership serves 4.2 million inner-city youngsters, or about 11% of the nation's public school enrollment. Approximately 32% of the nation's Black children, 27% of the Hispanic children, and 21% of the Asian children are being educated in our schools. Almost one-third of our enrollments are of children who reside in families receiving public assistance, and nearly 75% of our average enrollment is minority.

Mr. Chairman, the Council commends the Subcommittee for convening these hearings on S. 2294. I would like to restrict my testimony this morning to several issues concerning the Education of the Handicapped Amendments as passed by the Senate: the age 3-5 mandatory service program, the cost of the program, and collaboration of services with other agencies and federal efforts.

Like many of my colleagues who have testified before me, the Council firmly supports the notion that early intervention in the lives of young people pays enormous dividends in the future. The evidence for this continues to be overwhelming for handicapped and nonhandicapped children alike. Unfortunately, our society has often failed to make that investment in large enough doses to assure an enhanced quality of life for subsequent generations. It is quite clear that the need for early intervention with handicapped youngsters is large indeed. The Eighth Annual Report to Congress indicates that while approximately 260,000 handicapped children aged 3-5 receive special education, several times that many may still be in need. The total cost to fill that need is estimated to be about $2.7 billion annually.

The Council of The Great City Schools is proud of its longstanding support of- and advocacy for- children in our inner cities, for civil rights and the rights of the disenfranchised in our society--including those of handicapped children and their parents. We are also cognizant of the fact that until passage of PL 94-142 many public schools, including our own, were not as responsive to the needs of handicapped children as was appropriate--and we also recognize that there is some distance to travel. Our most difficult task, as a coalition of big city schools, is meeting the needs of our unusually large concentrations of the poor, the handicapped, the limited English-proficient, the hungry and the unemployed--and building our institutional capacity to do so.

The Council's endorsement of the concept of the proposed legislation is offered in that context. We strongly support meeting the needs of pre-school handicapped children but also believe that passage of the proposed legislation without the means to implement it is to dupe the kids we want to serve. While many of our school systems currently offer services to handicapped children aged 3-5, most have not done so on a comprehensive basis and would require large infusions of personnel, facilities, materials and other items to do the job that a new law would mandate. We will be pleased to work tirelessly for passage of S. 2294 if we know that the federal government will be as serious in its commitments to the handicapped as it is asking us to be.

Mr. Chairman, we commend the Committee for convening these hearings. The new mandates for serving children aged 3-5 do beg for considerable study. Our first recommendation, in fact, is that the Subcommittee continue these hearings by calling on witnesses from local school systems who would have to implement the law. We believe that the local administrators and school boards ought to try to estimate what capacities they now have and what would be needed in order to serve the 3-5 age group. It appears to us that this kind of information would be crucial to the Subcommittee; and the Council would be delighted to help identify witnesses.

The thirty-seven city districts comprising the Council of the Great City Schools currently serve over 420,000 handicapped children at an annual cost of about $1.7 billion from all local, state and federal sources. Approximately 11.1% of our total annual expenditures of $14.7 billion is devoted to special education, but individual district expenditures for the handicapped range from 6.1% in Dallas to 22.9% in Tulsa. Nearly 14% of our total full-time teaching staff is employed to teach the handicapped; 44% of our part-time teaching force; 32% of our full-time teacher aides; and 31% of our part-time aides (see appendix).

Most of this capacity is used to serve those aged 5 and over. Early childhood programs, in fact, are a fairly recent development for most city schools, many of whom did not offer even general kindergarten instruction until 15 or so years ago. We also estimate, for instance, that only about one in five eligible pre-schoolers in our cities receive Headstart services. In general, city schools are probably further ahead in their capacities to deliver pre-school services to handicapped children than to other types of children. The proposed legislation, unfortunately, puts us in the very uncomfortable position of having to develop further our capacities for the pre-school handicapped at the expense of other badly needed pre-school services. What is desparately required here is a national agenda that will recognize the pre-school needs of all of our children.

Still, the cities are operating pre-school special education programs in many places on a limited basis. These efforts involve cooperative arrangements under Title XX, day-care programs, assessment and remedial work and nursery schools, homebound and hospital programs, city-wide health screening--in multiple languages, preschool Chapter 1, parent-infant education, developmental screening and a host of others.

Dallas, for instance, has been operating an age 3-5 program since the passage of PL 94-142. It serves about 400 children in 36 classrooms at slightly over $4000 per child. The new Texas mandate to serve 4 year-olds in pre-K programs, while not exclusively for the handicapped, is expected to supply some additional dollars to the Dallas program but also additional children. It is worth noting that the Texas law provides leaway for LEAs to apply for waivers or phase-ins when dollars or specially trained teachers are in short supply. The Pittsburgh program, which is voluntary, serves about 150 to 170 three-to-five year-olds with EHA-B, preschool incentive grants and state funds--totalling about $575,000 or about $3,380/child. Services include diagnosis, speech therapy and others. Students not served by the schools are served--in larger numbers--by the Pennsylvania Welfare Department through contracts with public and private providers. Boston also provides services to this age group ranging from consultations to full-day programs at a cost of about $7000/child. (The appendix of this testimony has brief annotations of some of the pre-school efforts in various cities).

These efforts and others, while not comprehensive, are being implemented as quickly as possible on either a voluntary basis or through state requirements (accompanied by state aid). Additional federal requirements to serve 3-5 year-olds will be difficult for our schools to meet if they do not have the capacity. To develop it on a short-term basis will require expenditure cutbacks in other worthy areas or revenue increases that will be difficult to realize.

City School systems, as the Chairman knows, have been subjected to a host of federal budget cuts over the last several years, averaging about 40% in real terms. In addition, city budgets continue to suffer severe overburden problems, and the recent spate of state education reforms have been too sparse and to diffused in their benefits to have any targetted effect on cities. At the same time, old federal mandates may soon be joined by mandatory medicare coverage for all public employees, the elimination of a portion of the state/local sales tax, the elimination of revenue sharing, new constraints on the ability of local schools to earn arbitrage on their bond issues, the costs of implementing the Garcia case, asbestos abatement, new waves of immigrants and others.

Still, we believe that children aged 3-5 are deserving of services and we will do all we can to ensure them. To that end, the Council would like to make the following proposals to the Subcommittee for consideration.

1. Modify current law to provide for entitlement benefits for youngsters between birth and five years-old--with the federal portion set at least at 40% of entitlement.

   While this would be enormously expensive for the federal government, it would also be expensive to local and state sources who would have to meet the other 60% share. We include youth from birth because we see little reason for the federal government to distinguish the two age groups. Also, because all youth before age five and after the compulsory attendance age are not by law served by a public institution, they should, as individuals, be entitled to needed services as such. We would also encourage other Subcommittees to consider similar entitlements to other pre-school children. Finally, there should be a dedicated tax to meet the costs of this program.

2. Modify the current legislative proposal from one that puts the primary onus on public schools to one that coordinates other federal programs and local/state agencies as partners.

   It is clear from existing pre-school programs in cities that most are using a variety of funds and agencies to accomplish a task that is only partly educational. We would urge the Subcommittee to rethink the current approach in S. 2294 and explore how these services might be provided in collaboration with such efforts as Medicaid, Title XX, EPSDT, Headstart, Maternal and Child Health Block Grants, Child Welfare Services, WIC and others. While more complicated to draft, such a bill would probably be more comprehensive and less costly that S. 2294.

3. Coordinate services under the bill with efforts to reduce teen pregnancy and efforts to reduce alcohol and drug abuse.

   There is clear evidence that some handicapping conditions are either created or exacerbated by the use of alcohol or drugs in pregnancy, especially with young mothers. It seems to make sense to us to try to tie pre-K services to other federal, state and local efforts to address the issues of teenage pregnancy and substance abuse.

4. Develop a series of local capacity-building grants for LEAs in the

first three years of the program where no service mandates are in effect--or could be waived at the request of the LEA.

Such capacity-building grants could be used to make capital expenditures, train and recruit teachers, develop materials, plan, coordinate activities with other agencies, and purchase appropriate transportation.

5. Significantly build-up the funding for the pre-school incentive grants to attract greater programming for the 3-5 year-olds.

   Our city data appear to show that the pre-school incentive grant program has been extremely successful as a spur to additional pre-K programming. Additional incentives built into this existing effort could be useful as a way of nudging school systems into an area they would like to address anyway.

6. Take additional testimony from local administrators and school board members on the feasibility of the proposed legislation.

7. We would like to reserve further recommendations until later on the meshing of PL 94-142 mandates for the 3-5 age category until our field has additional opportunity to study the bill.

That concludes my testimony and I would be happy to try to answer any questions. Thank you.

Number of Students by Handicap

District	Total Special Education Enrollment	Mentally Retarded		Hard of Hearing		Deaf		Speech Impaired		Visually Handicapped		Emotionally Handicapped		Orthopedically Impaired		Other Health Impaired		Specific Learning Disabled		Deaf/Blind		Multi-Handicapped		Other	
		#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent	#	Percent
Albuquerque	9,330	320[a]	3.33	100	1.07	-	-	-	-	36	.38	-	-	110	1.30	-	-	3706	39.67	6	.06	269	2.88	4751[b]	50.93
Atlanta	4,494	1060[a]	23.59	4	.09	0	-	862	19.19	29	.63	551[d]	12.27	33	.72	20	.45	1077	24.10	0	-	831	18.46	-	-
Baltimore	18,629	1453	7.80	86	.47	40	.22	5306	28.47	125	.68	557	3.02	30	.15	69	.37	10902	58.53	3	.02	363	1.95	-	-
Buffalo	8,161	1329	16.28	33	.40	15	.18	2683	32.88	27	.33	1143	14.01	40	.49	10	.12	2833	34.71	0	-	48	.59	-	-
Chicago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cleveland	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Columbus	6,787	-	-	142	2.09	-	-	1026	15.11	71	1.05	-	-	303	4.37	-	-	2607	38.41	-	-	49	.72	2080[c]	30.66
Dade County	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dallas	9,386	1151	12.35	80	.91	-	-	2076	22.15	36	.38	490	5.33	90	.96	277	2.96	6401	67.00	13	.14	690	7.45	22	.23
Denver	5,903	873	14.79	97	1.64	-	-	1530	25.85	5	.05	797	13.50	86	1.43	3676	41.94	-	-	f	-	f	-	-	-
Detroit	16,618	2267[g]	13.90	490	2.95	21	.13	3851	23.18	296[h]	1.94	1276	7.68	612	3.80	1	-	4490	27.03	-	-	53	.32	-	-
Indianapolis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Long Beach	4,120	301	7.30	30	.68	31	.75	1309	31.36	29	.71	38	.93	169	4.11	79	1.93	2118	51.41	1	.02	38	.92	-	-
Los Angeles	46,402	4712	10.16	1030	2.22	666	1.43	8183	17.63	444	.96	2236	4.79	1623	3.49	5751	12.39	21236	45.76	14	.03	697	1.50	-	-
Memphis	12,116	3030	25.08	165	1.36	-	-	2209	18.26	100	.83	391	3.23	149	1.23	886	7.31	4210	34.75	10	.08	298	2.46	668	5.51
Milwaukee	9,100	1631	17.93	100	1.10	60	.67	2265	24.90	37	.43	1458	16.01	170	1.87	64	.70	3070	33.73	5	.06	93	1.09	-	-
Minneapolis	6,276	1276[j]	20.33	106	1.70	-	-	995	15.86	60	.95	634[e]	10.11	184	3.00	77	1.23	1673	26.66	0	-	-	-	36	.30
Nashville	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
New Orleans	7,252	1305	18.03	180	1.63	36	.67	2646	36.00	36	.74	1110	15.62	97	1.36	149	2.08	1772	24.63	1	.01	90	1.36	-	-
New York City	107,327	8060	7.48	982	.91	470	.44	3900	3.63	649	.60	16046	14.95	687	.56	17197	15.99	57136	53.23	13	.01	2009	1.96	376	.35
Omaha	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Philadelphia	22,730	3890	17.12	255	1.12	36	.16	4790	21.07	159	.70	2100	9.24	255	1.12	0	-	13730	60.40	0	-	0	-	-	-
Pittsburgh	5,996	1036	17.28	96	1.60	1	.02	2683[k]	44.71	97	1.62	506	8.50	60	.90	0	-	1516	25.40	0	-	-	-	-	-
Portland	6,660	250	3.75	3	.05	1	.02	1336	20.06	3	.04	636	9.30	60	1.00	39	.64	2303	33.65	63	.90	-	-	1	.02
Rochester	6,766	891	13.69	39	.61	63	1.30	919	19.28	11	.23	890	17.53	70	1.47	1	.02	1982	39.91	-	-	56	1.13	2	.04
St. Louis	6,765	2227	33.82	43	.62	14	.21	1360	28.28	23	.36	-	-	100	1.51	77	1.34	2094	38.45	-	-	-	-	838[e]	12.63
St. Paul	4,996	1073[c]	21.60	108	2.16	-	-	933	18.00	40	.80	750[e]	16.00	122	2.04	15	.30	1800	37.75	-	-	-	-	19	.30
San Francisco	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Seattle	6,277	917	13.09	37	.63	32	.75	636	14.82	18	.42	385	7.06	67	1.10	83	1.92	2303	53.05	1	.02	57	1.33	250[l]	6.03
Toledo	4,751	-	-	136	2.86	-	-	1377	28.00	50	1.05	-	-	176	3.70	1	-	983	19.08	-	-	113	2.38	2106[m]	44.33
Tulsa	5,686	1099	19.33	30	.53	43	.70	1379	28.76	13	.23	80	1.35	25	.44	6	.11	2077	36.13	0	-	122	2.15	-	-
Total	336,666	42979	363.36	4390	39.71	1564	7.32	53525	531.99	3617	16.66	31966	189.09	5190	63.03	27175	92.18	167000	900.22	100	1.36	6163	49.71	11672	139.17
Mean	13,928.17	1935.41	16.67	179.29	1.23	96.00	.69	2237.17	23.13	180.71	.69	1597.30	9.95	216.30	1.79	1313.75	3.12	6426.30	39.69	6.41	.12	361.22	2.93	972.67	13.36
Range	103,617	7792	29.97	1030	3.91	666	1.41	7669	39.37	667	1.59	16036	17.30	1590	6.08	17197	41.91	56251	36.56	62	.09	2009	18.36	4750	50.90

Footn

Number of Students by Ha[illegible]ap

a = includes educably and trainable mentally retarded

b = includes behaviorally and communication disordered

c = mildly through profoundly mentally retarded

d = includes behavior disorders

e = includes behaviorally and developmentally handicapped

f = included in other categories

g = educably mentally impaired through severely mentally impaired

h = includes blind

i = included in "orthopedically impaired"

j = moderately through severely mentally handicapped

k = includes some hearing impaired

L = pre-school handicapped

m = includes developmentally and severe behavior handicapped

District and Special Education Budgets

District	Total District Budget	Total Special Education Budget	Percent of Total District Budget
Albuquerque	300,346,500	31,551,353	10.50
Atlanta	186,440,846	12,336,166	6.62
Baltimore City	331,357,043	44,674,076	13.48
Buffalo	160,892,503[a]	11,390,137[a]	7.08
Chicago	1,800,000,000[b]	250,000,000[b]	13.89
Cleveland	327,000,000[b]	23,000,000[b]	7.03
Columbus	214,432,257	21,162,807	9.87
Dade County	-	-	-
Dallas	552,909,349	33,667,658	6.09
Denver	246,713,434	16,199,991	6.57
Detroit	-	-	-
Indianapolis	170,935,881	15,653,744	9.16
Long Beach	171,081,595	17,251,154[c]	10.08
Los Angeles	2,716,636,964[c]	247,273,785[c]	9.10
Memphis	233,880,318	15,700,218	6.71
Milwaukee	383,637,239	28,038,140	7.31
Minneapolis	120,602,888[d]	15,144,111[d]	12.56
Nashville	156,837,232[e]	19,511,482[e]	12.44
New Orleans	-	-	-
New York City	3,899,365,010	497,594,253	12.76
Omaha	123,302,191	10,400,001	8.43
Philadelphia	934,082,900[c]	101,948,000[c]	10.91
Pittsburgh	228,990,000	36,904,825	16.12
Portland	251,785,294	45,023,680	17.88
Rochester	168,208,291	18,825,281	11.19
St. Louis	238,650,445[c]	23,189,460[c]	9.72
St. Paul	130,900,868	17,680,698	13.51
San Francisco	252,000,000[b]	28,600,000[b]	11.35
Seattle	172,370,742	12,266,815	7.12
Toledo	133,299,167	12,749,521	9.56
Tulsa	122,207,670	27,991,518[f]	22.90[f]
Total	14,728,866,627	1,635,728,875	11.10
Mean	541,046,805	61,253,586	10.26

Footnotes

District and Special Education Budget

Note: All figures represent FY 1984 or FY 1985 and/or school year 1984-85 unless otherwise indicated.

a = estimated for 1983-84 school year

b = estimated

c = 1985-86 figures

d = 1983-84 figures

e = does not include federal funds; not included in mean or range

f = includes several private and other programs not funded by the district; not included in mean or range

Student Enrollment

District	Total Enrollment in District N	Special Education Enrollment in District Facilities N	 Percent	Special Education Enrollment in Programs Operated by Other Public Agencies N	Special Education Private Day Placements N	Special Education Residential Placements N	Special Education Homebound Instruction N	Total Enrollment in Non-Public Schools N
Albuquerque	77,222	9,330	12.08	-	110	-	122	-
Atlanta	66,570	4,528	6.80	126	-	23	13	-
Baltimore	112,000	17,212	15.37	-	669	45	99	-
Buffalo	46,619	8,448	18.16	457	361	116	3	14,150
Chicago	428,038	41,373	9.71	43	2,722	434	28	128,317
Cleveland	74,171	5,734	7.72	150	0	0	150	77,000
Columbus	67,051	6,075	9.07	143	0	143	176	17,115
Dade County	228,062	21,815	9.56	205	-	22	2,233	50,255
Dallas	130,616	7,037	5.39	207	70	-	78	-
Denver	57,727	4,811	8.33	185	50	344	54	450
Detroit	189,651	10,743	5.66	160	0	13	58	736
Indianapolis	54,062	6,859	12.69	26	10	3	46	9,086
Long Beach	63,892	4,110	6.45	37	17	0	5	17
Los Angeles	560,266	46,492	8.30	32	1,303	210	168	-
Memphis	106,935	12,114	11.34	29	233	17	886	220
Milwaukee	92,533	8,987	9.71	0	15	0	6	31,464
Minneapolis	37,456	4,968	13.26	838	-	717	36	10,278
Nashville	63,366	5,839	9.22	0	143	13	50	16,767
New Orleans	81,393	9,270	11.39	106	57	88	8	300
New York City	932,000	105,803	11.36	-	1,306	1,321	1,463	6,328[a]
Omaha	41,632	5,600	13.45	33	325	25	75	12,000
Philadelphia	197,900	24,989	12.62	-	970	29	901	96,357
Pittsburgh	40,257	5,956	14.79	-	300	6	35	17,387
Portland	51,003	4,923	9.65	905	140	5	63	325
Rochester	32,830	4,606	14.27	12	255	28	68	31
St. Louis	51,059	6,765	13.21	1,978	80	4	31	-
St. Paul	30,972	4,715	15.22	0	0	100	1	13,393
San Francisco	62,979	6,012	9.55	0	350	7	62	27,175
Seattle	41,303.48	4,362	10.49	128	8	34	-	12,750
Toledo	42,922	4,751	11.07	281	-	159	103	11,706
Tulsa	46,091	5,606	12.72	100	0	100	340	-
Total	4,106,376.48	420,761	339.37	6,181	9,450	4,076	7,067	566,495
Mean	132,463.76	13,572.96	10.95	237.73	350	140.55	235.57	22,768.96
Range	901,908	101,693	12.77	1,978	2,722	1,321	2,232	128,300

[a] Includes Hospital schools

District Employment of Teachers and Aides

District	Number of Teachers Full-Time	Special Education Teachers Full-Time		Number of Teachers Part-Time	Special Education Teachers Part-Time		Number of Aides Full-Time	Special Education Aides Full-Time		Number of Aides Part-Time	Special Education Aides Part-Time	
		N	Percent		N	Percent		N	Percent		N	Percent
Albuquerque	3,996	887.80*	22.23	117	-	-	679*	-	-	100	-	-
Atlanta	4,162	348	8.36	-	-	-	556	64	11.51	-	-	-
Baltimore	9,112	1,621.30*	17.79	-	-	-	1,156	335.60*	29.03	-	-	-
Buffalo	3,157	562	17.80	19	1	5.26	905	155[a]	17.13	147	-	-
Chicago	24,435	3,304	13.52	-	-	-	2,015	298	14.79	-	83	-
Cleveland	4,500	538	11.96	0	0	-	116	106	91.38	0	0	-
Columbus	4,087*	510	12.48	-	0	-	427*	85	19.91	-	3	-
Dade County	12,336	1,379	11.18	0	0	-	926	355	38.34	0	0	-
Dallas	7,629	688	9.02	4	-	-	906	225	24.83	8	-	-
Denver	3,447	389	11.29	1,194[b]	5	.42	1,558	208	13.35	110[c]	2	1.82
Detroit	8,531	1,173	13.75	26	15	57.69	1,642	218	13.28	160	-	-
Indianapolis	5,720	430	7.52	1,661	-	-	454	130	28.63	-	-	-
Long Beach	2740.86*	249	9.08	22	-	-	368	153.67*	41.76	-	-	-
Los Angeles	24,859	2,390	9.61	69	-	-	3,828	2,240	58.52	7,366	90	1.22
Memphis	5,506	528	9.59	-	-	-	557	227	40.75	6	6	100
Milwaukee	5,204	808	15.53	-	.60*	-	865	154	17.80	-	2*	-
Minneapolis	2,514*	387	15.39	-	147	-	353*	8	2.27	-	423	-
Nashville	3,590	387	10.78	0	-	-	370	183	49.46	0	-	-
New Orleans	4,851	744	15.34	-	-	-	1,050	393	37.43	-	-	-
New York City	51,297	9,993	19.48	291	291	100.00	9,099	3,722	40.91	-	-	-
Omaha	2,463	352.40*	14.31	-	-	-	359	122.91*	34.24	343	-	-
Philadelphia	11,888	1,840	15.48	196	-	-	2,758	786	28.50	-	-	-
Pittsburgh	2,740	245	8.94	18	-	-	550	114	20.73	-	-	-
Portland	2,500[d*]	376.45[d*]	e	292	-	-	138	271.24[d*]	f	563	-	-
Rochester	1,975	390	g	-	0	-	319	161	50.47	50	0	-
St. Louis	3,418.45*	457	13.37	-	-	-	269	14	5.20	-	0	-
St. Paul	2,333.50*	684.90*	29.35	-	-	-	454	381.24*	83.97	223	-	-
San Francisco	3,600	356	9.89	145	17	11.72	103	6	5.83	2,000	378	18.90
Seattle*	2331.25	297.90	12.78	-	181	-	317.49	181	57.01	-	-	-
Toledo	2,417	365	15.10	-	2	-	-	-	-	280[h]	94	33.57
Tulsa	2,425	341	14.06	51	46	90.20	332	42	12.65	0	-	-
Total	229,767.06	33,021.95	394.98	4,105	705.60	265.29	33,427.49	11,339.66	889.74	11,396	1,079	155.51
Mean	7,593.07	1,088.18	13.62	761.47	50.40	44.22	1,114.25	395.30	31.78	667.88	83	31.10
Range	49,322[i]	9,748	21.83	1,661	291	99.58	8,996	2,234	89.11	7,366	423	98.78

Footnotes

District Employment of Teachers and Aides

a = Total teacher aides, full and part-time demarcation not clearly indicated

b = Substitutes

c = Full-time non-instructional

d = Includes part-time, not included in mean

e = Combined full and part-time = 13.6%

f = Combined full and part-time = 38.6%

g = Combined full and part-time = 19.7%

h = Full and part-time demarcation unclear, requires clarification

i = Probably greater depending on the actual full and part-time breakdown for Rochester

* = Number(s) indicate full-time equivalents

Special Education Teachers Employed by Category

District	Mentally Retarded[a]	Hard of Hearing[b]	Deaf[c]	Speech Impaired[d]	Visually Handicapped[e]	Emotionally Handicapped[f]	Orthopedically Impaired[g]	Other Health Impaired[h]	Specific Learning Disabled[i]	Deaf Blind[j]	Multi-Handicapped[k]	Other[l]
Albuquerque*	55.10	9.70	1.10	235.50	2.10	166.60	10.50	-	376.60	-	25.00	-
Atlanta	122	8	6	49	6	63	8	-	80	0	-	8
Baltimore*	348	7.6	18	149.00	25	55	11.50	35.2	444	-	13.40	65
Buffalo	196	9	6	0	7	90	8	1	230	0	13	0
Chicago	916	0	209	236	100	616	233	-	994	-	9	193
Cleveland	223	30	30	61	15	38	26	16	120	0	18	-
Columbus	182	0	61	37	10	87	33	0	118	0	17	-
Dade County	308	40	0	128	26	80	36	51	633	-	-	71
Dallas	301	50	-	80	0	73	11	1	67	3	21	64
Denver	83	26	0	36	6	86	26	0	150	1	0	0
Detroit	444	60	7	136	37	136	63	7	363	37	-	17
Indianapolis	300	5	-	30	3	29	7	3	137	-	7	-
Long Beach	36	9	0	11	0	-	15	0	-	-	-	172
Los Angeles	236	138	0	235	27	60	165	0	785	3	83	579
Memphis	111	62	-	66	18	27	16	2	716	1	35	16
Milwaukee	135	29	0	150	11	162	39	0	233	1	0	38
Minneapolis	79	16	-	64	-	69	11	-	132	-	62	16
Nashville	68	30	-	40	11	17	-	12	192	0	22	18
New Orleans	360	29	6	100	13	129	13	15	1	1	6	93
New York City	916	26	90	197	61	1,790	166	1,793	4,728	-	230	62
Omaha*	39	17	-	36	7.60	-	15	-	180.55	-	-	130.65
Philadelphia	625	56	-	368	27	187	37	-	735	-	-	367
Pittsburgh	65	8	0	9	3	46	5	1	90	0	7	18
Portland*	3	-	30.20	21.15	10.50	-	7.50	6	-	3	5.00	276.50
Rochester	71	6	0	-	3	72	2	0	130	0	6	90
St. Louis	176	8	7	6	5	93	11	0	87	0	0	110
St. Paul*	160.40	-	28.00	86.10	15.50	136.00	37.50	-	150.00	2.00	-	60.00
San Francisco	41	2	30	29	7	27	7	6	211	1	15	-
Seattle*	-	11.50	0	-	5	-	5	-	-	-	-	278.00
Toledo	157	7	17	32	5	66	0	22	56	0	16	16
Tulsa	93	-	26	23	3	13	6	-	186	6	6	0
Total	6,629.50	676.80	638.10	2,080.55	438.50	6110.40	981	1,962.20	13,221.75	47.60	906.00	2626.95
Mean	214.30	25.06	30.56	66.23	15.38	152.26	33.86	130.81	436.69	3.39	37.13	105.00
Range	916	138	207.90	360.50	98	1770	231	1,793	4,727	37	230	579

Footnotes
Special Education Teachers Employed by Category

a = Part-time: Total = 44; Mean = 4.40; Range = 29
b = Part-time: Total = 8; Mean = .89; Range = 5
c = Part-time: Total = 0
d = Part-time: Total = 44; Mean = 4.40; Range = 30
e = Part-time: Total = 7.60; Mean = .63; Range = 1.00
f = Part-time: Total = 19; Mean = 1.58; Range = 13
g = Part-time: Total = 1.80; Mean = .18; Range = 1
h = Part-time: Total = 0
i = Part-time: Total = 395; mean = 32.27; Range = 391
j = Part-time: Total = 1; Mean = .11; Range = 1
k = Part-time: Total = 19; Mean = 2.11; Range = 16
l = Part-time: Total = 76; Mean = 7.60; Range = 66
o^{2} = Part-time Reported = 1
o^{3} = Included in "Deaf"
o^{3} = Included in "Deaf"
o^{3} = Included in "orthopedically impaired"
p^{3} = Included in "hard of hearing"
p^{1} = Hospital/Homebound
q^{3} = Part-time Reported = 2
q^{3} = Included in "hard of hearing"
q^{4} = Part-time Reported = 1
q^{5} = Part-time Reported = 1
q^{6} = Included in "orthopedically impaired"
q^{3} = Part-time Reported= 1
r^{3} = Part-time Reported = 1
r^{3} = Included in "hard of hearing"
r^{4} = Part-time Reported = 11
r^{5} = Part-time Reported = 1
r^{6} = Included in "orthopedically impaired"
r^{7} = Part-time Reported = 1
r^{1} = Part-time Reported = 1
s^{3} = Included in "hard of hearing"
s^{3} = Part-time Reported = 1.00
s^{4} = Included in "orthopedically impaired"
s^{1} = Part-time Reported = 31
t^{3} = Included in "hard of hearing"
t^{3} = Included in "orthopedically impaired"
u^{3} = Included in "hard of hearing"
u^{3} = Part-time Reported = .60
u^{4} = Included in another category
u^{5} = Included in another category
v^{3} = Part-time Reported = 39
v^{3} = Part-time Reported = 5
v^{4} = Part-time Reported = 70
v^{5} = Part-time Reported = 13
v^{6} = Part-time Reported = 1
v^{7} = Part-time Reported = 60
v^{8} = Part-time Reported = 16
v^{1} = Part-time Reported = 5
w^{1} = Included in "multi-handicapped"
x^{3} = Includes educationally handicapped and some learning disabled
y^{3} = Part-time reported = 391
z^{1} = Acoustically handicapped
a_1^{2} = Part-time Reported = 15
a_1^{3} = Included in "hard of hearing"
a_1^{4} = Part-time Reported = 1
a_1^{5} = Part-time Reported = 1
a_1^{6} = Part-time Reported = 1
b_1^{1} = Included in "Deaf" and "visually impaired"
b_1^{3} = Included in "hard of hearing"
c_1^{1} = Included in "orthopedically impaired"
d_1^{3} = Part-time Reported = 12
d_1^{3} = Part-time Reported = 77
e_1^{1} = Part-time Reported = 2
e_1^{3} = Included in "hard of hearing"
f_1^{2} = Included in "Deaf"
f_1^{3} = Part-time Reported = 1
f_1^{4} = Included in other "health impaired"
f_1^{5} = Included in "multi-handicapped"
f_1^{1} = Part-time Reported = 1
g = Part-time Reported = 46
* = Number(s) indicate full-time equivalents

Special Education Aides Employed by Category

District	Mentally Retarded[a]	Hard of Hearing[b]	Deaf[c]	Speech Impaired[d]	Visually Handic.[e]	Emotionally Handic.[f]	Orthopedically Handic.[g]	Other Health Impaired[h]	Specific Learning Disabled[i]	Deaf Blind[j]	Multi-Handic.[k]	Other[l]
Albuquerque	-	-	-	-	-	-	-	-	-	-	-	-
Atlanta	27	5	-	-	-	26	6	-	-	-	-	-
Baltimore*	173.60	-	18	-	-	35	-	1	62	11	13	-
Buffalo	-	-	-	-	-	-	-	-	-	-	-	135[m]
Chicago	80[n]	0	43	-	2	86	11	-	16	-	9	31
Cleveland	34	0	5	0	4	11	28	0	0	0	24	-
Columbus	8	0	9[p]	0	3	37[p]	20[p]	4	0	0	11	-
Dade County	185	9	-	0	7	67	41	10	26	0	-	10
Dallas	63	0	8	6	1	50	25	6	4	2	38	20
Denver	54	9	-	0	0	109	6	9	41[p]	0	0	0
Detroit	345	7	r	11	1	22	35	9	4	2	-	-
Indianapolis	71	-	-	-	-	14	14	3	18	-	10	-
Long Beach*	63.67	3.95	r	5.22	1.07	-	16.20	9	-	-	-	83.76
Los Angeles	313[o]	97	0	-	.19	118[t]	221	9	777	4	90[t]	600
Memphis	50	21[s]	-	-	8[s]	35	22	7	24	2	82	-
Milwaukee	43	1[o]	r	4[v]	1[v]	33	37[b]	u	13	1	w	20
Minneapolis	8	9	-	0[x]	-	3[e1]	2[h1]	-	3[i1]	-	0[l]	4[l]
Nashville	64	12	-	10	-	16	-	-	36	21	24	33
New Orleans	130[g1]	14	4	0	1	129	13	6	0	1	4	85
New York City	681	3	75	75	23	1,631	3	348	658	-	409	98
Omaha*	31.12	5.28[k1]	-	-	1.36	-	23.96	-	18.48	-	-	50.83
Philadelphia	276	19	-	10	8	164	48	-	263	-	-	0
Pittsburgh	22	4	r	3	-	22	7	1	30	11	13	16
Portland*	1.50	-	36.84	-	3	-	26	4.30	-	-	4	196.60
Rochester	38	3	r	1	0	41	3	0	33	0	13	10
St. Louis	0	1	0	0	0	3	8	0	3	0	0	0
St. Paul*	93.93	-	21.50	23.90	7.30	108.10	20.70	-	48.49	.70	-	56.30
San Francisco	3[l1]	51	11	-	t	w[l]	1[y]	m1	n1	t	7[p1]	-
Seattle*	-	9.90	-	-	-	-	50.50	-	-	v	-	121
Toledo	7	-	-	-	1	40	q1	18	-	21	15	13
Tulsa	10	-	4	-	1	1	6	-	6	5	9	-
Total	3629.64	213.73	172.14	99.12	96.63	2,841.20	693.36	397.50	1912.17	28.70	732	1,607.49
Mean	97.39	11.87	15.65	5.83	4.60	118.38	25.67	30.58	83.13	1.91	39.58	80.37
Range	681	97	43	23.90	23	1,630	221	348	777	11	409	600

Footnotes

Special Education Aides Employed by Category

a = Part-time: Total = 259; Mean = 23.54; Range = 90
b = Part-time: Total = 15.74; Mean = 1.75; Range = 11
c = Part-time: Total = 15; Mean = 2.50; Range = 14
d = Part-time: Total = 7.25; Mean = .80; Range = 7
e = Part-time: Total = 2.25; Mean = .25; Range = 2
f = Part-time: Total = 117; Mean = 10.64; Range = 75
g = Part-time: Total = 137.75; Mean = 13.75; Range = 125
h = Part-time: Total = 6; Mean = 1.20; Range = 6
i = Part-time: Total = 263; Mean = 26.30; Range = 213
j = Part-time: Total = 2; Mean = .22; Range = 2
k = Part-time: Total = 109; Mean = 12.11; Range = 80
l = Part-time: Total = 51; Mean = 7.28; Range = 51
m = Total teacher aides full and part-time, demarcation not clearly indicated
n = Part-time reported = 83
o = Included in "Deaf"
p = Part-time reported = 1
q = Included in "orthopedically impaired"
r = Included in "Hard of hearing"
s = Part-time reported = 90
t = Part-time reported = 2
u = Part-time reported = .75
v = Part-time reported = .25
w = Reported in other categories
x = Part-time reported = 25
y = Part-time reported = 11
z = Part-time reported = 7
a_1 = Part-time reported = 75
b_1 = Part-time reported = 125
c_1 = Part-time reported = 49
d_1 = Part-time reported = 80
e_1 = Part-time reported = 51
f_1 = Included in "Multihandicapped"
g_1 = Includes educationally handicapped and some learning disabled
h_1 = Acoustically handicapped
i_1 = Included in "deaf" and "visually impaired"
j_1 = Part-time reported = 61
k_1 = Part-time reported = 3
l_1 = Part-time reported = 14
m_1 = Part-time reported = 39
n_1 = Part-time reported = 6
o_1 = Part-time reported = 213
p_1 = Part-time reported = 27
q_1 = Included under "other health impaired"
* = Number(s) indicates full-time equivalents

Required and Optional Participants in District IEP Meetings

City	Administrator	Spec. Ed. Coord/ Supervisor	Child Study Team Rep.	Principal (designee)	Referral/ Classroom Teacher	Spec. Ed. Teacher/ Specialist	Psychologist/ Assess. Team	Social Worker	MD/Nurse	Parent	Child (if appropriate)	Other
Albuquerque[a]		*		X	O		O		O	X	X	O
Atlanta			*		X	X	X	O		X		O
Baltimore City[b]		*					O			X		O
Buffalo			*		X	X	X	O	O	X		
Chicago				*	X	X	X	X	X	X		O
Cleveland		O		X	X	O	O		O	X	X	
Columbus[c]		O		O	O	O				X		O
Dade County[d]					X		X			X	X	X
Dallas	*				X	X	X		O	X		O
Denver		X		X		X		O		X	X	X
Detroit			X		X							X
Indianapolis					X	X	X	O	O	X	X	X
Long Beach	*				X		O			X		O
Los Angeles	*				X		O		O	X		O
Memphis				X	X	X	O	O		X		X
Milwaukee	X				O	*				X	X	O
Minneapolis	*				X	X	O	X		X		O
Nashville				X	X	X	X			X	X	O
New York City				O			X	O	X	X	X	X
New Orleans					X			O		X	X	X
Omaha			X		X					X	X	*
Philadelphia		O		X	X		X			O		
Pittsburgh		X		X	X	X	X			X		O
Portland		X			X	X	O	O		X		O
Rochester		X		O	X	X	X	O	X	X		
St. Louis												
St. Paul				X	X	X	O	O	O	X		O
San Francisco	X				X	X	X			X	X	
Seattle	O				X	*	X			X	X	X
Toledo		O		X	X		*			X		
Tulsa	X				X	X	O			X		O

[a] Two of the optional are required.
[b] Depends on nature of student's handicap.
[c] Special education supervisor, principal, or designee and teacher (present or proposed)
[d] Representative of district other than student's teacher
*Chairperson

Please describe any preschool and primary grade programs in the district designed to reduce remedial and compensatory needs.

ALBQU - The Early Childhood Special Education Teacher program screens all potential Support Team referrals of children kindergarten age. Recommendations are made allowing children to be maintained in the kindergarten class. A small program providing special education services in an integrated class at the kindergarten/first grade level and at the first/second grade level allows for the integration of the more moderately handicapped child, reducing needs for remedial and compensatory programs.

ATL - Summer school, Title XX Day Care, Title XX Cook--Perry Homes Outreach Program (Parent instruction in the home).

BALT - Pilot preschool programs, pilot all day kindergarten.

BUFFALO - Early Intervention Program, Special Needs Intervention Program, Positive Team Approach, and Early Push Program assess those children who may be viewed as "high risk" and plan appropriate intervention programs.

CHI - 1. A large Headstart program serves over 5,000 children between the ages of 3 and 4. 2. A program titled Early Assessment and Remedial Laboratory evaluates preschool children and determines levels of cognitive and social/emotional functioning. Test results are utilized to develop an individual program to remediate deficiencies. The program emphasizes parent training in areas of child development, management, nutrition, etc. Through parent involvement it is felt that the child will benefit from intervention at home as well as in the school. Many parents need training to be able to provide support to children. 3. Full day kindergarten programs are provided through ECIA funding. The mandated instructional program is implemented in the morning and enrichment activities are scheduled for the afternoon hours. Individualized remedial instruction is offered to students that are exhibiting difficulties in readiness areas. Teacher aides and parent volunteers work closely with the teacher to provide additional support. 4. There are 25 Child Parent Centers in the City of Chicago. Parents may enroll their children at age 3. The focus is on parent education. Specially trained teachers and ancillary staff work with parents and their children. Topics of instruction may include health education, utilization of community resources and GED preparation. Counseling and parent support groups are an integral part of this program. An expansion program is proposed to extend the services of the Child Parent Center to children in the 1st and 2nd grades. This is contingent on funding. The above programs emphasize early identification of children at risk and remediation of difficulties before the child is too far behind.

CLE - Extensive Early Childhood program for regular pupils. Please note description of Special Education Programs - Developmentally Handicapped.

COLUM - There are no pre-school programs. Early identification of reading problems in 1st and 2nd grades and concentrated efforts with remedial programs in both grades.

DADE - Programs of instruction are provided for parents of pre-school handicapped children, for students 0-3 years of age who are deaf, blind, deaf/blind, and hearing impaired in a program for the homebound. All other exceptionalities are served in schools.

DALLAS - Districtwide screening in speech and health.

DENVER - We have two regular education preschool programs. One is a Chapter I program and the other is funded through local funds. Both Early Childhood Education programs have structured pre-reading, pre-math and other readiness skills curriculum for 4 and 5 year old children, 5 days a week. To attend the programs in Chapter I schools, the children must qualify for Chapter I placement (below the 30th percentile). Beginning in the 1986-87 school year, children in the other ECE programs will be taken "on the greatest need basis." A special education program for children as young as three who have a significant hearing loss is available to reduce remedial and compensatory needs. The Hearing Handicapped Early Childhood Education Program stimulates language development and auditory training. Parents are encouraged to participate in the program in order to learn to assist in their child's language development. Three remedial and compensatory primary programs in the district are available. One is the bilingual/ESL program. Another is the Instructional Assistance Program (IAP) which provides supplemental language and reading instruction with a "whole language" approach. IAP teachers both work within the classroom and on a pullout basis. The third, Program for Pupil Assistance provides individual assistance on a pullout basis and is geared to helping the disruptive child who is also falling behind in class. In addition to district programs, remedial classes have been developed in many schools to meet specific needs of their pupils.

DETROIT - Preschool, program extended day kindergarten, regular services for the 1st, 2nd and 3rd grade students.

IND - Early Prevention of School Failure - to identify potential learning difficulties. Transitional first grade - for students who are developmentally behind cognitively physically and in the area of psychomotor skills.

LNB - E.C.I.A. Chapter 1; E.I.A. - Bilingual; school improvement.

MEMP - Los Pasoss, Rehabilitation Center, U.T.-Child Development Center, Headstart, Kindergarten

MILW - Four Year Old Kindergarten; Head Start; Specialty Schools; Project RISE; Chapter 1 Program.

MINN - Early childhood and family education programs are provided for youngsters birth to four years of age. Intervention kindergarten and primary grade programs are also offered.

NASH - Chapter I reading and math support; local transition classes T-1 (first grade intervention for students not mature enough to enter regular programs) and T-4 (fourth grade remedial program for students not ready for middle grades).

NEW ORL - Seventy-one preschool teachers and tutors work with 1278 pre-kindergarten children in regular school setting to provide skill building activities.

NYC - NYC implemented a reduced class size program in the early grades. In addition, various Community School Districts in NYC offer individualized programs providing instructional and/or pupil personnel support to low-achieving or high risk students and families.

OMA - Birth to 5 years of age preschool handicapped program; pilot Alternative Kindergarten program (extended day - emphasis on language development); Chapter I reading and math program; reading and math aides.

PHILA - All preschool programs have this effect. We have Head Start, Get Set, Child Care and Parent Cooperative Nursery plus Follow Through.

PITT - Forty three agencies comprise membership in Local Children's Team (see attached brochure) - all provide programs/services to reduce remedial/compensatory needs.

PORT - Chapter I is a federally funded program providing compensatory education for targeted public school attendance areas. The program is based on low income studies and student achievement needs. State funds are provided through the State Disadvantaged Child program to sending and receiving schools for compensatory education programs for low achievers. Basic Skills Improvement Funds provide compensatory education programs for schools who have sufficient numbers of low achievers to qualify. The money is provided by the school district. (See Part I, Document 8.2)

ROCH - Three pre-school programs for students serving both identified handicapped and non-handicapped students.

ST LOU - 1) Pre-school and full-day kindergarten programs funded through Desegregation monies; 2) Chapter I Pre-School; 3) Parent Infant Interaction Program for parents of pre-school children; 4) Developmental Screening of children ages 1-2 years and parent education.

ST PAUL - We provide special education pre-school for youngsters beginning at the time of diagnosis.

SEAT - CAMPI - see attached newspaper article.

TOLEDO - Early Childhood Program - Early identification and treatment of pre-school students, ages 2-5.

TULSA - Tulsa Public Schools has a Chapter I Early Childhood Program for 4 year old students.

Mr. **Williams**. Thank you, Mr. Bartlett.

Mr. **Bartlett**. Thank you, Mr. Chairman.

Let me begin with a broad question, if you will, for each of the three of you, on the subject of the 0 to 2. Could you describe for us who is presently providing services in the 0 to 2 range? The second part of the question is: In your judgment, should that provision of services be placed properly in the education area or elsewhere, health, social services? What should the role of the local school district be if we were to make it education services. Would the local school district be a help or a hindrance?

Ms. **Sylvester**. Mr. Bartlett, who provides services? Let me give you an example in Vermont in the County of Burlington. We have what is called a community based program for essential early education services from 0 to 5. It's not mandated. Understand that.

What we have is what is called a home based coordinator who goes and visits the families who have been referred to the early ed center by the Child Development Clinic which does the diagnosis and referrals of handicapped youngsters.

This home based coordinator, based on what is needed by the child, really coordinates the services for this particular family. If you have Down syndrome, for example—Chris, that I was talking about, had a home based coordinator who visited with the family. It was their first child. They really didn't know what to expect with the child who had that diagnosis. Talked about early intervention, infant stimulation, taught the child how to——

Mr. **Bartlett**. Ms. Sylvester, let me stop you at that——

Ms. **Sylvester**. Is that what you're talking about?

Mr. **Bartlett**. Yes, it is, and let me be very specific. Who then, who does the home based coordinator? Who hires that person to——

Ms. **Sylvester**. Education. Division of Special Education.

Mr. **Bartlett**. The local school board?

Ms. **Sylvester**. Right. Under the local school board. There is a lot of coordination between the Child Development Clinic, which does a lot of diagnosis and referral, to the essential ed service center. It's like a center based program where people come from different regions to visit there.

Mr. **Bartlett**. So, after then the home based coordinator, who is an employee of the school district—Is that correct?

Ms. **Sylvester**. Right.

Mr. **Bartlett**. Does the diagnosis and refers the child and the parents to other agencies. Are the other agencies typically within the school district or somewhere else?

Ms. **Sylvester**. Yes. In our particular area, if the child is needing occupational therapy or physical therapy, they have both, the therapist on contract at the Early Ed Center. So the family doesn't have to go to a thousand different places for their services.

Being in Vermont, because it's so small, everybody knows everybody else. It's not like you have to go to twenty different places.

Mr. **Bartlett**. Same thing in Texas.

Ms. **Sylvester**. Absolutely right. So we really do have a lot of traffic for cooperation in interagency agreements on the state level and local level. I see it, just from a parent's perspective; and you ask, should it be placed in the educational area. It's just kind of an easier entry level, in our State anyway, to go through the educational agency, because then you don't have to be dealing with twenty different people. But to make sure that there is definitely some cooperation and a lot of talking with the other service providers in that area.

Mr. **Bartlett**. So at least in Vermont, the educational model has worked well.

Ms. **Sylvester**. Only 13 percent are served. It's based on school board discretion on who does it.

Ms. **Berman**. Mr. Bartlett, we've worked with a number of States that have different models, and we have found that a lot of flexibility is needed here; because, for example, some States have preferred to have the education agency the lead because in those cases there's a natural linkage to the educational system later.

However, in other States the Health Department has been found to have the first contact with the child, and in terms of the first question you asked, you know, who is delivering the services. So many of the providers of services to the very youngest child are in the health professions. And so many times early intervention begins prenatally. We're able now to begin helping babies even before birth, at the moment of birth, in the nursery.

Then there are other States in which they have found that a council of a cluster of agencies has been a better option. For example, in Texas the Early Intervention Council works very effectively, and it is completely independent although it's housed in the health agency, but it is fiscally independent and programmatically independent of that agency. It's just housed there.

So I think the important thing is to recognize that there's a broad array of practitioners, and that you need to have flexibility in allowing the States to decide how they want to work this program out. But the most important thing is that the lead agency or the council or however it's worked out has to ensure that the other agencies that are participating are going to have a voice in the policymaking decision, because otherwise those dollars aren't going to continue to flow. They aren't going to want to cooperate.

Mr. **Casserly**. If I might comment from the school system angle, I'm not sure what's true in many of the cities is the same as what's true in Vermont where you have a whole host of social service agencies that are often larger in dealing with extremely complicated issues and populations.

I think the norm, at least for many of our districts, is that most school districts do not have programs for birth to 2 year olds, nor do they have the capacity or the experience to involve themselves in programming. Some school districts, including the Dallas school district in fact, has a birth to 2 year old program; but the school district's involvement in it is more built around coordination and diagnosis and some homebound instruction, but they're not the lead agency for that population. They just don't have the experience to do it.

Mr. **Bartlett**. Second question is: Could each of you enlighten us as to how we could quantify or how you would describe, or has anyone described, the savings that occur to schools, the educational agencies, in later years as a result of early intervention? Has anyone attempted to quantify that; and if you can't quantify it, how would you describe those savings?

It would seem to me that those savings are apparent from an anecdotal viewpoint, but I think the committee needs to try to get a handle on where those savings come from and how large the savings are in later school years as a result of early intervention.

Mr. **Casserly**. Well, I think there is plenty of anecdotal evidence to indicate that early intervention, as all of us have said, pays enormous dividends in the future. I think Congressman Miller's subcommittee has tried to do some cost estimates, if I remember right, about a year ago about the amount of money that is saved by the expenditure of a single dollar on various early intervention programs. I don't know whether the subcommittee here has taken a look at that, but that's an excellent study and part of public law 94-142 as one of the programs to look at.

Ms. **Sylvester**. A specific example that I gave of Mary Beth who is severely hearing impaired—She has another counterpart which I didn't tell you about, a 4 year old just like her who was in an area where there was no early intervention.

Early intervention is when I talked about the home based coordinator who came in and helped the family such as Mary Beth and talked to the family about hearing impaired and what have you.

The other 4 year old is without services at this point in time, and the chances are that she will probably end up at the Austeen School for the Deaf in Brattleboro which is roughly $20,000 a year. Mary Beth is having an interpreter in her regular kindergarten, and the cost of that is $6–$8,000 a year.

I know they're all anecdotal or storytelling, but the problem is I wish that we could all say, okay, let's take the dollar sign on my niece Cathy. You know, they were told to put her in Brandon Institution. Brandon this year is $56,000 per year. She's now going to a regular high school program with the aid of a consulting teacher whose salary is—what?—$20-$22,000, and the consulting teacher is serving more than one Cathy. She's serving 20 people on her caseloads, modifying and adapting her program.

So I think that there are all sorts of ways that you can do your dollar signs, but when you think of institution versus school, and then you think of special ed classroom which is a self-contained classroom that costs at least—what?—I don't know how much—the Division would have that. I don't have that off the top of my head.—versus Cathy being in a totally integrated setting, and she now has a part-time summer job, and she wants to work. She's not going to be collecting supplemental security income when she graduates. She will have some type of employment and be paying for her own apartment.

Obviously, you can tell by my feeling that there really is evidence, and I think maybe we just need to get better at, you know, costing it out. And I don't—that's not my style. I don't cost it out all the time. I'd much rather talk about the quality and what's happening to the people who have to have that label of a disability. But it's there, I'm sure.

Ms. **Berman**. I think that there are a variety of studies that show the cost effectiveness. I think that the statement that you've just heard speaks to those. There are others that relate specifically to environmental risks that might be of interest.

Dr. Sally Province at Yale University Child Study Center showed a savings of about $40,000 per child for a year, where there was an intervention with a family early on.

I think, more importantly, we can't always look in hard dollars at the value of what we do with early intervention. I really think that not only the productivity of the child as an adult in dollars is what we ought to be looking at. I think that there's a societal value that you can't place a dollar sign on, and——

Mr. **Bartlett**. Thank you. Thank you, Mr. Chairman.

Mr. **Williams**. Mr. Hayes. Any questions?

Mr. **Hayes**. Just to follow-up so I'll be clear. Thank you, Mr. Chairman—with Ms. Sylvester. Maybe Ms. Berman, I'd better start with you first. You just finished.

Are you saying in effect—so I'll be clear on your position—you have been—People who testified here represent other organizations who are for the continuation of the program and expansion, but they tied it to funds to support expansion or the continuation. Are you saying that even without this you think that, without supporting funds or knowing where the money is going to come from, we should go ahead and pass 2294?

Ms. **Berman**. Well, Mr. Hayes, I haven't spoken to the funding question. I do think that issue certainly needs to be explored. I haven't addressed it.

I think that there are a lot of funding streams that are available from the Federal Government to the States and within the States, and that things can be worked out. I do think that the important thing that I've spoken to are the concepts that early intervention does make a difference, and that I support the bill because it provides early intervention at or before birth.

I think about the worst thing that we could do is to open it up and then not provide anything and, you know, raise expectations. I think that parents and infants have been waiting for a long time, and they're hoping that something is going to happen now, and that what you do now will have an effect over the next 70 or so years, the life expectancy of these children.

I'm not answering your question very well, because I don't really know about the dollars, but I do think that people——

Mr. **Hayes**. I think I understand what you are saying. Ms. Sylvester, do you share that opinion?

Ms. **Sylvester**. I'm looking at it more from a public policy viewpoint also and giving the lead to the State, direction, so to speak, so that there is equity no matter what State you're living in, not having to rely on the discretion of your school board.

It's encouraging to know at least that the estimates haven't gone up. It's now down to the millions rather than the billions. I'm not a fiscal analyst. I think that whatever you can provide for states for assistance ought to—

Mr. **Hayes**. Some of the analysts shouldn't be fiscal analysts.

Ms. **Sylvester**. Right. I know for Vermont, Mr. Hayes, that to educate the unserved preschoolers from 0 to 5 would require $2 million, and our State legislature has only done $50,000 each year.

Given that track record, it will be 4 years probably before they get there. So that's how Vermont will do.

Mr. **Hayes**. Just to look at my State of Illinois, currently under the program 12,948 students in the 5 year category are being served. 5,049 students are 4 year olds being served; 2,405 3 year olds are being served.

Obviously, there are a lot of kids who need who are not being touched or served in my State at all. Maybe you could just briefly tell me, based on your own organizations' operations, what is the criteria for the admittance of students into the program, just briefly?

Ms. **Sylvester**. For the essential early education?

Mr. **Hayes**. That's right.

Ms. **Sylvester**. It's really like an eighteen month discrepancy based on the chronological age and testing which is done. It's not handicapping labeling. It's developmentally related.

Right now in Vermont we're serving 692 ages 3 to 5, and 169 are going unserved out of a total population of 10,300 handicapped students from birth to 21. But it is based on the testing and chronological age, an 18-month lag which some people feel is too rigid, but that's how we use it.

Mr. **Hayes**. Obviously, lack of funds is one of the deterrents, I think.

Ms. **Sylvester**. Definitely.

Mr. **Hayes**. I notice, Mr. Casserly, in your statement you said the eighth annual report to Congress indicates that approximately 260,000 handicapped children aged 3 to 5 in special education; several times that many still are in need.

You say the total to fill that need is estimated to be about $2.7 billion annually. That seems to me a rather low figure, 260,000 being served nationally. We don't have any figures or numbers of kids who need but are not being served.

Mr. **Casserly**. Mr. Hayes, I suspect that estimate is low, too. I based it on previous testimony before the subcommittee, but I suspect the level of need and the cost is considerably greater, which is why I'm skeptical of the Department of Education's numbers that were just put out.

It would certainly make it easier if the Department were correct. $315 million is certainly a lot easier to come up with than $2.7 billion, but I wouldn't doubt for a second that the estimate of need that's listed there is low.

Mr. **Hayes**. On page 2 of your testimony you state that the Council of Great City Schools endorses the concept of the proposed legislation, but also believe that the passage of the proposed legislation without the means to implement it is to dupe the kids we want to serve. Could you expand on that a little bit?

Mr. **Casserly**. I would agree with Ms. Berman, that if we're to pass this legislation, whatever its form and whatever its age—whatever age group it addresses, that we have to have the capacity to actually make good on our promises or we're simply falsely raising the expectations of the children and parents who definitely need services.

We don't quarrel at all with the need or the desire to have those children's needs met. Our school systems are in the very difficult position of having to balance needs of not only preschool handicapped children but nonhandicapped children as well on extremely limited resources, as you know.

Mr. **Hayes**. I could ask more, but I kind of feel that I should show some restraint. I've just been shown some figures here that, according to the Congressional Budget Office, eighty percent of the eligible students for this program are currently being served. And according to their estimates, only about 70,000 students nationally are not being served.

Mr. **Casserly**. This is out of the Congressional Budget Office?

Mr. **Hayes**. Yes. I don't know whether—Department of Education.

Mr. **Casserly**. I don't know if GAO has tried to do any kind of estimate of this or not, but if they have, you might want to look at that.

Mr. **Hayes**. I think we ought to take some steps to try to get some accuracy on those figures as to the kids who actually should have the benefit of this kind of educational program that are currently not getting it. It seems to me—I know there are a lot of black kids who are handicapped, and Hispanic kids who just don't have an opportunity to be exposed to this kind of program.

Mr. **Casserly**. I agree.

Mr. **Williams**. Ms. Berman, with regard to the definition of at risk, should poverty alone be the indicator for the at risk child?

Ms. **Berman**. No. I think that there are—If a child is not disabled and they're poor and they're in a caregiving environment that's nurturing and where there are parents that are giving them the attention that they need to develop, there's nothing about poverty that would place that child at risk.

Mr. **Williams**. What do you mean by disabled?

Ms. **Berman**. Well, for example, let's take a child—Would you just ask me the question again, what do you mean by disabling?

Mr. **Williams**. Well, you said poverty alone, if the child is not disabled, should not be the indicator. And I said, well, what do you mean by disabled?

Ms. **Berman**. Oh. OK. There are children who are born with biological risk conditions combined with situations in which there isn't somebody who is providing them a nurturing and supportive environment. We would consider these children doubly vulnerable.

Those children certainly need to have some kind of an early intervention program. There are other children where there isn't a biological risk. There's no reason to suspect biologically. There's nothing that happened at birth that would lead you to suspect that they're going to have a problem. But perhaps their situation is that they have a retarded mother or that their mother has been a substance abuser or there's some suspicion of abuse. That child would be placed—I would consider at risk for environmental or experiental reasons, because they may not be able to get the kind of care and attention that a child needs for normal development.

Maybe no one is going to be talking to them or holding them. Just because a child is poor doesn't give that child an experiential risk. There are lots of very loving homes——

Mr. **Williams**. That child you've just described now whose mother or father or both may be drug abusers, the parents are found to be not fully fit to care for the child—Are you saying that, even though that child is born without a biologically disabling condition they should be placed at risk under this bill?

Ms. **Berman**. I think they at least should be looked at. First of all, the most important thing is that in the earliest years you have tp have a program of early identification. You have to at least identify the children. So there's a much broader umbrella of who you're looking at.

I'm not suggesting that a child be seen on a daily basis by a high tech team, but to include—to have a wide prevention program, and then if you see that there's something that may place this child at risk of needing some more intervention, then certainly you might want to consider whether you're going to follow that child along. So the answer is yes.

On the other hand, I wouldn't want to place a label, and I wouldn't want to stigmatize that child. You just want to see how they develop, and help them if they're not developing.

Mr. **Bartlett**. Would the Chairman yield?

Mr. **Williams**. Yes.

Mr. **Bartlett**. I appreciate the Chairman yielding on that point. I wonder if each or any of the witnesses could describe what is happening today in terms of school districts and educational agencies that are providing services to the birth through 2 population, how the definition is developing today that's different from what perhaps you have advocated?

Mr. **Casserly**. I think I'd probably have to get you more specific information, which I'd be happy to do. I suspect it's kind of hodge podge of definitions that are being used. This is really a two-edged sword, unfortunately, the use of the term "developmentally delayed."

It doesn't have the labeling potential that any of the other categories does. For that reason, there's a great deal of merit. On the other hand, often some of the categories under 94-142 are not consistently enough defined and are often used, quite unfortunately, either to over-label or to categorize in disproportionate numbers large numbers of black kids and Hispanic kids as handicapped that really shouldn't be so categorized.

From our standpoint, I think the "developmentally delayed" terminology is meritorious, but I'd like to see a bit more definition drawn around that term rather than it being left quite so open-ended. But I'd be happy to try to get you some specific information from individual school districts about how the term and other terms are used at the age level.

Ms. **Berman**. There is quite a variation nationally. In New England, the States of Massachusetts and Maine, for example, use the definitions that you have from the Senate report, the environmentally at risk, biologically at risk, established risk or handicapped. I think it varies from State to State, and I think that they've chosen how they define the population to be served based partly on some sort of evolutionary thing of what services are available.

It's better to serve a wider umbrella of children than to begin to look at children from a preventive context.

Mr. **Bartlett**. Thank you.

Mr. **Williams**. Ms. Berman, in your review of the early intervention programs, what services are considered mandatory? Mandatory health services.

Ms. **Berman**. In my review of early intervention programs, what services are considered mandatory health services?

Mr. **Williams**. Yes. In the programs you reviewed. Do they include services provided by physicians for other than diagnostic purposes, respite care? Nursing services?

Ms. **Berman**. It varies from State to State what services are mandated, and many States have permissive laws and there isn't a mandate. Frankly, I can't answer your question very specifically.

Mr. **Williams**. Let me put it in another way. Is our understanding of appropriate services such that we can define and require all States to provide that service or those services? Is our understanding without the lack of inclusiveness to such a degree that we should allow fifty States to provide fifty different services for the children within them?

Ms. **Berman**. Mr. Chairman, I'd really like to take some time to think about that question and come back with an answer later. I'm not comfortable giving you an off the cuff answer.

Mr. **Williams**. I'd appreciate it if you would—I understand and appreciate your wanting to consider that a bit. I'd encourage you to try to write to the subcommittee and provide us with your sense of the answer within two weeks.

[The response follows:]

AUG 1 3 1986

NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS

August 7, 1986

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The Honorable Pat Williams
Chairman, Subcommittee on
  Select Education
Committee on Education and Labor
U.S. House of Representatives
617 House Office Building
  Annex #1
Washington, DC 20515

Dear Mr. Williams:

A question you asked me at the July 29, 1986 hearing on S.2294 was: "What services, particularly health services, should be Federally mandated?". You also asked whether I was aware of State laws that have addressed health services and, if so, whether I might specify what some of these have been. Rather than speculate or give a vague answer at the time, I offered to check with some of the States that have laws regarding early intervention and to supply a response within two weeks. I am now writing to supply my response.

1. What services, particularly health services, have been mandated by States?

In the State laws I've reviewed, specifics about the nature of early intervention services appear in the rules, standards of care, and guidelines issued by executive agencies assigned to carry out the mandate, but not in the statute, per se. Following are examples from a few States. I have not explored all mandates.

In **Texas**, the Early Childhood Intervention program (ECI) covers evaluations performed by physicians and nurses. These may be medical or developmental evaluations. The ECI program also funds specialized diagnostic examinations--such as audiological or neurological testing. Periodic re-evaluations are also allowable. The ECI program requires that other funding sources be used first, such as private insurance and other State dollars--Crippled Children's Services, for example. ECI funds do not cover reconstructive surgery, hospitalizations, nor extensive medical treatment. Dr. Mary Elder (telephone 512/465-2671)

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who administers the ECI program explained that the intent of covering medical evaluations is to ensure that the health program is consistent with the educational program. ECI does not want to supplant the primary health provider, rather they want to include them as a team member.

I asked about the role of nurses and found that the nurse has a major role in the Texas ECI program. Nurses monitor medications, tube feeding, and immunizations. They check for apnea. They help explain medical reports to parents and to the team. They might accompany parents to the physician's office. They offer guidance on nutrition, safety, and child rearing. They might see a child who is medically fragile as often as three times per day. In Texas, some early intervention programs have nurses on the staff. When there is none, a local health department nurse might work with the EI team. In this case, the nurse's salary would not come from ECI funds, but his or her work with the team would be an integral part of the program. I asked Dr. Elder what is not covered and she explained that ECI is not designed as a medical treatment program. Thus, medication is not covered, nor are immunizations. In reality, a nurse making a home visit might give the mother help on the spot with such primary health needs, because it's practical to do so; but that is not the program's intent.

Nutritionists are seldom involved in the ECI program in Texas, because nutrition services are typically performed by nurses. It has not been considered a "core service."

Massachusetts has a State mandate for early intervention which requires the health department to provide, facilitate and coordinate services to handicapped and at risk children from birth to three years. Karl Kastorf and Andrea Weiss (telephone 617/727-5089) have been helpful to me in clarifying how their law effectively permits many health services to be covered. The Massachusetts law does not specify what services must be provided other than to stipulate through their standards that a team must include at a minimum a "developmental educator" and two others. Regardless of professional discipline, Massachusetts early intervention (EI) services must be family centered, team oriented and related to developmental outcome. Thus, a pediatrician who consults with the EI team may be reimbursed for a developmental assessment, but pediatricians generally do not request nor receive reimbursement for routine health supervision. Similarly, nurses do health monitoring/surveillance and parental guidance, a part of early intervention that is not only allowable but encouraged by the team. Nursing services related to routine health maintenance, such as administering immunizations, are generally not covered by EI funds. Rather, these services are paid from other sources. I asked about nutrition services and was advised these are available through Massachusetts EI, both preventively and therapeutically, generally by referral. For example, where there is a suspicion of failure-to-thrive syndrome, referral may be made by the team for nutrition, social work and psychological assessment/intervention. Preventive nutrition counseling is also needed by many parents with low birthweight infants or where diet may contribute to behavior, such as in the case of hyperactivity or lethergy.

In **New Jersey**, another State with a mandate from birth, an interdepartmental committee has developed approval criteria for any public or private agency to receive funding for services under the early intervention program (EIP). The core team in New Jersey's EIP must be comprised of appropriately credentialed professionals, including "early childhood/special education teacher(s), occupational therapist(s) or physical therapist(s)." Additionally, at least two of the following are required: psychologist(s), registered nurse(s) and social worker(s). Other specialists as needed are permitted. For teams serving hearing impaired children, there are additional requirements for teachers of the deaf and others. The nature of screenings, assessments, family involvement, and eligibility are spelled out in these criteria as well. One problem New Jersey has faced has been the shortage of specialized personnel, perhaps because of the degree of specificity. Moreover, their eligibility standards appear to exclude children who are at the "margin" of eligibility where early intervention could prevent the need for more intensive services later. Most referrals to the EIP come from physicians in the private sector. If a child who needs early intervention has not had a medical work-up by a primary care physician, and the family does not have resources to pay for such, EIP funds will cover a basic work-up. A more extensive medical evaluation is not included in the EIP mandate. However, if one is needed, it can be covered by MCH funds, through a combination of Federal and State dollars. Susan Goldman (609/292-5676) or Andrea Quigley (609/292-0147), in the Health and Education Departments, respec- tively, would be pleased to clarify questions about how the law works in New Jersey.

In **Maryland**, Department of Education regulations (COMAR 13A.05.01) define "related services" to include "speech pathology, audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disability, counseling services and medical services for diagnostic or evaluation purposes." While this definition does not relate exclusively to early childhood services, it covers the range of programs covered under the State law, according to Janeen Taylor (telephone 301/659-2498) who is the coordinator of Maryland's State Development Grant. The Maryland rules define early childhood programs as those designed to provide a program of intervention directly to handicapped children from birth through four, to their parents, or to both. Itinerant personnel are permitted to serve as a resource to the parent. In Maryland, state and local education agencies coordinate with state and local health departments and the University Affiliated Faculty in Baltimore on an ad hoc basis in the provision of services that are health related. Funding streams such as EPSDT and Crippled Children's Services support specialized health related services. Dr. Polly Harrison, Assistant Director of the Office of Infant, Child and Adolescent Health Services (telephone

301/225-6749) and Dr. Judson Force, Chief of the Division of Crippled Children's Services (301/225-5580) would be good resources for clarification on health services in the State of Maryland.

In **Iowa**, there is a mandate for early intervention from birth which permits children to enter the special education system through virtually any route. Parents may directly contact their local or intermediate school district for an assessment and services. Each intermediate district (Area Education Agency) is charged with developing a "child find" program which involves encouraging referrals from parents, pediatricians and others. Naturally, there is not uniformity with respect to the degree that health providers are involved in various school districts. The health department is a common referral source and works cooperatively with special education; but education dollars generally do not pay for "health" services, nor vice versa. Frank Vance (319/281-3176) or Joan Clary (319/281-5614) in the Special Education Department and Dr. John MacQueen, Director of the Iowa Child Health Specialty Clinics (CCS) (319/353-4431), can all be instructive in explaining Iowa's system of services. Support services under special education include occupational and physical therapy, psychology, speech pathology and audiology, social work, preschool consultation and school health services provided by school nurses. Neither physicians nor nutritionists are part of the special education system, per se. The health system operates thirteen regional centers where high risk infants are seen for evaluation and development of a plan of care. The regional center staff is comprised of representatives from three State agencies, including health and education. Depending on the nature of follow-up needed, the lead may be taken by the physician, special educator or social worker. The team also includes a nutritionist. A more comprehensive, multidisciplinary follow-up at the University of Iowa's University Affiliated Program may be requested; or the child may be followed in a home based infant stimulation program supported and staffed by special education.

According to Ron LaCoste (504/342-1641), **Louisiana** has a limited mandate, including only evaluations or educational assessments from birth. The education regulations delineate professionals whose services are covered, including, for example, occupational and physical therapists, audiologists and speech/language pathologists, assessment teachers, pediatricians and other licensed medical professionals. Certain other disciplines, such as nurses, are not mentioned in the regulations and thus reimbursement for their assessments might be questioned.

The question of how "related services" are defined and interpreted has long been a source of concern in most states. There is sometimes an impact on what services will be covered by agencies outside of Education. In **Washington**, for example, where the mandate extends down only to 3 years, Crippled Children's Services (CCS) generally will not serve children covered under "related services" by Education, even if the amount of services available from Education are considered inadequate by the professionals prescribing them. For instance, Dr. Susan Baxter (telephone 206/753-1233) states that if a child requiring occupational therapy is scheduled once weekly, but three times per week had been recommended; neither Education nor Crippled Children's Services seems willing to cover the additional occupational therapy appointments. Dr. Baxter observes that, when the determination of eligibility is made locally rather than by the State agency, there seems to be a better chance of coverage. This example illustrates how so-called "related services" become entangled with funding issues rather than meeting the child's needs, unless states are given flexibility to work these matters out.

Utah is among the States without a mandate from birth. My conversations with nurses who have managed the Infant Development Program, Christie Kaminsky (801/538-4575) and Athleen Coyner (801/-292-4777), serve to illustrate that cooperative arrangements among agencies can enable practitioners from various disciplines to provide needed services. Under a subcontract from the State Education Agency, the Infant Development Program (housed in the Health Department) employs nurses to follow infants who have significant need for health supervision, such as babies who are intubated or where there is a complicated medical diagnosis. In such cases, the nurse takes on a case manager role, generally because of a team decision. These nursing personnel are paid for from Federal Education dollars (Chapter I of P.L. 89-313). Other nursing personnel employed by local health departments have similar responsibilities, but part of their salaries come from MCH/Title V dollars through the State Health Departments. A major difference is that the nurses supported under Title V tend to work in well baby clinics where there is more emphasis on preventive health maintenance and thus assess or treat fewer infants with complicated diagnoses. In order to ensure that a child doesn't have one nurse to change the tube and another nurse to conduct a developmental assessment, Utah has found it best to consider ways to work cooperatively across agencies.

North Carolina, another State without a mandate from birth, has relatively few federal education dollars flowing into early intervention. There is a High Priority Infant Program funded through an appropriation to the Health Department from the State Legislature. This program uses many health practitioners to identify and track infants at risk of disability. There are also two networks providing services from birth. These include Early Childhood Intervention programs for MR/DD children, and Developmental Evaluation Centers that offer evaluations and treatment on a sliding fee basis. Few school-operated programs serve handicapped and at risk children under the age of three. According to Gene Perrotta (telephone 919/-733-7437), Clinical Management Consultant with the DD Branch in the Division of Health Services, special education personnel constitute a minority in these programs, which are mainly staffed by health and mental health professionals.

2. What services should be mandated by the Federal government?

Having talked with program administrators in many States and across many disciplines, and having worked as a speech and language pathologist for several years, one conclusion is obvious to me. There should not be so much specificity in Federal law as to exclude services rendered by any group of practitioners.

It is arbitrary whether some services are considered "health" or "educational" in origin. For example, the services of a physical therapist, occupational therapist, audiologist or speech and language pathologist are generally included in early intervention programs in most States. There is no one logical basis for deciding whether these are to be placed under the umbrella of "health" or "education." In this same sense, the services of other practitioners, whether they are a nurse, psychiatrist, pediatrician, pediatric neurologist, psychologist, educator, social worker, nutritionist or parent, are part of "early intervention" when they involve the identification, assessment and enhancement of the child's physical, cognitive, social and/or emotional development, either through direct contact with the child or through work with parents and others in the child's immediate environment. It is essential, especially in the earliest years of a child's life, for health and education agencies and personnel to work together because of the intimate relationship between health and development.

Permitted flexibility and a broad interpretation of the nature of services to be provided, States have been creative in finding ways to serve disabled and at risk infants. There are too many structural differences in the way State agencies interface with each other and with the private sector for the Federal government to stipulate what services should be included or excluded. States need to be permitted to establish their own range of services to be provided within the various funding streams available to them.

There are several ways for the Federal government to seek to ensure that services are comprehensive. One is to insist that the services to be made available be approved by State Early Intervention Councils. If the Council includes various agencies contributing to the funding of the early intervention program and parents whose personal experience is not far behind them, there is a reasonable expectation that children will receive the kinds of services they need. A second is for the Federal government to support and publish the results of a study, or a series of studies, of services provided by each State. If the study includes statistics on the population being served and addresses quality assurance mechanisms, it will give States (and the Congress) a basis for comparison across States.

I hope this response is useful. I have tried to be as specific as possible, and would be pleased to supply further clarification if you wish.

Also attached to this letter is a copy of *Equals in This Partnership*, a publication about parent-professional relationships, which I referenced in my oral testimony, and an article on the effectiveness of early intrvention by Stanley I. Greenspan and Karl R. White, published in NCCIP's bulletin, *Zero to Three.* Next week I plan to forward two scholarly papers, whose principal authors are Edward C. Zigler and Victoria Seitz. The latter papers are intended to elaborate on my response to Mr. Bartlett's and Mr. Hayes' questions about the effectiveness of early intervention and the population to be addressed. Perhaps these four documents could usefully be appended to the materials to be published concerning this hearing.

Thank you again for your sincere and continuing interest.

Respectfully yours,

Carol Berman

Carol Berman
Director of Development

CB:dn

Mr. **Casserly**. Mr. Chairman, if I might——

Mr. **Williams**. Mr. Casserly.

Mr. **Casserly**. It seems to me that—Well, I don't have an answer to it either. It seems to me that this is one of the crucial questions that the subcommittee needs to answer about—before this legislation moves forward, and that is what services are absolutely necessary for this preschool group, and before we start addressing who ought to be the lead agency in providing those services.

I'm afraid that we may have—While the schools have enormous capabilities, they are not always the best people to provide some of the services that these kids need. It's absolutely a crucial question that needs to be answered.

Ms. **Berman**. I'd like to re-emphasize also that I don't think that the schools themselves would be the provider of all services, including health services. As I mentioned in my testimony, there are multiple funding streams, and there are an array of services at the state and community level that require coordination, and I don't think that—For example, I don't envision having a pediatrician working in the schools, in the center, identifying children. And yet there are services that a pediatrician and that a nurse, child psychiatrist and a nutritionist provide that are part of the umbrella of early intervention services.

That doesn't mean they're going to have them in P.S. 112. So many of the services are home based.

Mr. **Williams**. Ms. Sylvester, do you know the average cost per child in Vermont for full services?

Ms. **Sylvester**. I'm trying to think of the analysis that the Division recently did. Don't quote, but I would say the average per pupil cost was $4,500 to $6,000 based on the amount of services that a child required. But I'd have to go back and look at that for sure. I haven't looked at that for a while.

Mr. **Williams**. The CBO used an average cost of $2,000 to $4,500, which I think most of our witnesses indicate is low and would seem to inflate the costs of both CBO and DOE beyond what they have provided for us.

Mr. Casserly, would you expand some on your suggestion that we might consider other than the school districts as being—I don't quite know how you put it, but being other than the lead agency? Let me ask a question in this context. It would seem to me that, if the schools are required to provide this full range of services, the schools would want to have authority to go along with that responsibility, and thus would want to have a major voice in the lead agency, or perhaps be the lead agency themselves.

If I understand your suggestion correctly, you are recommending other than that.

Mr. **Casserly**. It's not a position we're taking. It's just another possible option that you might want to look at.

Mr. **Williams**. How would it work? What are you suggesting?

Mr. **Casserly**. Well, I'm not sure I've thought this through sufficiently. Before I answer, let me mention that also in my testimony, since you asked the question about cost, as I indicated, in the city of Boston which has—where the State mandates a 3 to 5 program, the full service program per child in that city is about $7,000 per child, although I've heard estimates that range up to $12,000 in some cases. But $7,000 is probably not out of the ballpark.

The suggestion was made for two reasons. One, because the school systems, it seems to me, for the most part, while many of them are doing birth to 5, any of the services that are required for that age group, while partly educational, are not wholly educational; and many of the services that these children require might best be met through some other social sagency in the community. You wouldn't necessarily need to pour enormous amounts of start-up cost into a public school system in terms of transportation and personnel and equipment and materials and all of that, but rather ran the main part of the program through some other social service system.

Pennsylvania does part of that where they use the public welfare department, and the public welfare department contracts with various agencies, public and private, at the local level.

Another reason why the suggestion was made is that one of the unfortunate aspects of 94-142 that experience has shown for individual school systems is that, once the school system has the onus or the responsibility for meeting the needs of kids in the 5 to 17 range, many social service agencies, in order to deliver related services, have pulled back their cooperation with the school system.

I think, and one of the fears that I have is, if the school system is the lead agency for the 0 to 5 school age or the preschool age kids, that we'll see what is now a lot of cooperative efforts with social service agencies at the local level being diluted. It would seem to me, for this age group, that to ensure that those agencies play a bigger part in this, that they be given more responsibility for this.

Mr. WILLIAMS. Let me clarify this cost matter which I mentioned earlier. I don't want to place misleading information in the record, so I want to focus on this matter of cost.

CBO had earlier indicated in a letter accompanying S. 2294 that the total number of unserved children aged 2 to 5 who would be entitled to services under the bill would range from 265,000 to 600,000 and, therefore, the additional cost would range between $530 million to $2.7 billion.

Within the last day or so, Department of Education has come up with a different estimate, not with regard to the cost of the program but with regard to the number of unserved children. They indicate that the number of unserved 2 to 5 year olds is closer to 70,000.

Our subcommittee staff then using CBO's cost per child estimates came up with the $315 million figure. The CBO per child estimates, by the way, are lower than Department of Education's per child estimates.

CBO says that the average cost per child could be around $4500, whereas Department of Education indicates that it's closer to $7200. Thus, using Department of Education's cost per child, we wouldn't arrive at a figure of about $315 million, but closer to $500 million or so.

Mr. Casserly, you indicated that the subcommittee should perhaps consider the receipt of additional information from some of your member schools who may want to provide us with that information concerning specifics of the legislation. It's clear, of course, that the legislative clock is ticking, and there aren't many legislative days left. The subcommittee does want to receive as many suggestions, as much information as we can.

We do not know at this point if we are going to have additional hearings. Neither do we know that we are not. However, because the clock is ticking, I would encourage you to reach a few of those school districts and ask them to submit to us within the next 2 or 3 weeks, if possible, any suggestions that they have in writing. I'd appreciate that.

Mr. CASSERLY. Mr. Chairman, it's already in the mail.

Mr. WILLIAMS. Very good. So is the check—we wish.

The statements of each of you will be included in their entirety in the hearing record. The material you have submitted will be included in the subcommittee files. The Department of Education has also asked that the hearing record be left open so that they can submit comments and recommendations, and that, too, will be done.

We appreciate each of you being here this morning. You've been very helpful, and our thanks.

Mr. WILLIAMS. The second panel is Ann Kinkor, Liz Vincent, Samuel Meisels, David Davis.

Ann Kinkor is a parent from Rancho Palos Verdes, California, representing the Epilepsy Foundation of America. We're pleased to have you with us today, and you may proceed.

TESTIMONY OF ANN KINKOR, THE EPILEPSY FOUNDATION OF AMERICA

Ms. KINKOR. Good morning, Mr. Chairman and members of the committee. It is a pleasure to be here.

Mr. Chairman and members of the subcommittee, my name is Ann Kinkor from Los Angeles County. Two of my four sons have epilepsy. Kevin developed epilepsy when he was 3 years old. He is now 10, and is the Epilepsy Foundation's National Poster Child for 1986. Patrick, age 11, has experienced seizures for the past two years.

I have a Master's Degree in Speech Pathology and have worked for approximately thirteen years in special education classes in Pennsylvania and California, providing speech pathology services to children of all ages from preschool to high school.

I am here to testify on the importance of and the need for early intervention services for infants and children with epilepsy. I am testifying on behalf of the Epilepsy Foundation of America, the only national nonprofit organization dedicated to the prevention of epilepsy and to providing—improving the lives of children and adults with this disorder.

Epilepsy affects approximately one percent of the general population, and some professionals estimate that up to 2 percent of all young children suffer from some form of seizure disorder. Seventy-five percent of all epilepsy occurs during childhood, with 30 percent occurring before the age of 5.

The Epilepsy Foundation represents a broad spectrum of children who attend either regular education classes, remedial or special education classes. In special education children with seizures can be found in classes for those who have learning, physical, behaviorial, mental and sensory disabilities. Many of the children in special education classes might be in regular education classes if intervention had been available to them at an early age, or at the onset of the seizure disorder.

Epilepsy is a collection of symptoms called seizures, which are outward signs of temporary and sudden disturbance in the normal pattern of electrical activity of the brain. Epilepsy takes on many forms, many of which are not easily identified. Many, in fact, do not involve convulsive seizures.

My son Kevin has atypical absence seizures, one of the most common forms of epilepsy in young children. These seizures are often mistaken for daydreaming, inattentiveness, or lack of intelligence.

As I mentioned, Kevin began having seizures when he was three. During a seizure, he stares into space for a short period of time, and then he falls asleep. His sleep varies from 5 minutes to 5 hours. Some children have up to 200 absence seizures per day, which have an understandably severe impact on their learning.

My son Patrick has complex partial seizures. His seizure activity begins with a tingling in the left side of his neck and is followed by severe jerking movements on the left side of his body for 15 to 30 seconds. Sometimes he experiences three or four of these seizures during a 15 to 20 minute period. Both boys are taking medication which only controls their seizures 85 percent of the time.

Seizures in young infants can often be the first indicator that an infant is developing another disabling condition. Deficits such as mental retardation and developmental delay are not uncommon consequences of seizures in early childhood. In addition, the correlation between learning disabilities and seizure disorders are very high.

Both disabilities are, in many cases, related to the same insult to the brain suffered early in life. In addition, repeated seizures and/or the effects of medication can result in the development of learning problems.

Mr. Chairman and members of the committee, I'm aware that you've heard many reasons why S. 2294 is a cost effective measure, but as a parent I cannot overemphasize the fact that early intervention and preschool education programs are particularly cost effective for infants and children with epilepsy. Early intervention can sometimes be sufficient to reverse or ameliorate a child's epilepsy, which might otherwise become a lifelong disability. In addition, early intervention may eliminate 10 to 15 years of special education later in life.

Furthermore, the need for related services such as speech and language therapy, adaptive physical education, counseling and close medical monitoring by school personnel could be reduced or eliminated if children were provided comprehensive early intervention and preschool education services.

The cost of these related services increases as a child grows up. Thus, in the long run, the programs provided for in S. 2294 will save millions of dollars each year in special education costs, let alone the cost of emotional stress that children with epilepsy and their families often face.

My son Kevin's experience illustrates this point. He was diagnosed at age 3 as having auditory memory problems related to his epilepsy, as well as growth and fine motor problems. He did not receive comprehensive therapy to remedy these problems because we could not afford the only available services. Our insurance plan did not cover these services, and we were not eligible for Medicaid.

Kevin did not begin speech and language therapy until he was in first grade, when he was identified as needing special education services. At that time he needed speech and language services three times a week. He has continued to need these services for the past 5 years.

His growth and fine motor abilities were one to two years behind grade level in the first grade, and he has needed adaptive physical education services three times per week for the past 5 years as well.

He also needed school counseling for 5 years to help him with the psycho-social problems he developed as a result of having seizures since early childhood. In addition, Kevin needed close medical monitoring, because his seizures were not effectively controlled.

All of these related services that Kevin has required in elementary school and will probably need through his intermediate and high school years might not have been necessary if he had received a comprehensive preschool education program at the time he was identified as having epilepsy.

Kevin's problems are typical of many children with seizures. However, many young children experience more severe learning disabilities as well as psychological and behaviorial disorders which often require placement in residential treatment programs.

If these children with severe deficits due to epilepsy had received early intervention services as infants and as preschoolers, their treatment program might have required less intensive remediation; that is, they could be placed in special education classes in public schools rather than in an institutional setting, and many more could have benefited only from remedial education services.

As a representative of the Epilepsy Foundation of America and as a parent, I cannot overemphasize the need for counseling and family support services for families of infants and children with epilepsy. The understanding and the acceptance of parents and siblings are crucial to a child's ability to cope with the seizure disorder.

Common family reactions to epilepsy range from rejection to overprotection. These reactions can be more damaging to a child's emotional wellbeing than the epilepsy itself, and the psychological scars left by these reactions often follow a child throughout his or her life and prevent him or her from becoming an independent, contributing member of society.

During the past year, while Kevin has been the Epilepsy Foundation of America's national poster child, I have received hundreds of letters and phone calls from parents of infants and young children who have epilepsy. All of these parents have told me of the stress and the struggle they have experienced in coping with their child's epilepsy and the tremendous impact their child's seizures have had on their lives.

All parents of children with epilepsy, especially parents of small children, live in day to day fear of their child injuring him or herself during a seizure. Can you imagine what it is like for a parent to watch their child have a seizure while he's learning to walk?

Many parents of preschool children have told me of the emotional harrassement their children experience in school. Several parents reported that they had to remove their children from private preschool programs because of their child's seizures.

All of these tensions can create great stress on family life. These parents are all struggling to provide their children with opportunities for growth and development and to maintain harmony in the family unit.

My husband and I have exhausted our savings to provide our two children with adequate medical counseling and educational services. We have been very fortunate to be able to do this. However, we are an exception. Most families of children with epilepsy are not able to provide their infants and young children with the services they need.

If children with epilepsy do not receive the early intervention and preschool services they need during the most crucial years of their development, it is likely that they will experience difficulty in school and in the job market later on. Becoming a productive member of society will be a dream, not a reality, for many of these children, unless early intervention services are provided.

Mr. Chairman and members of this committee, parents of children with disabilities across the country look to the Federal Government for leadership to ensure that their children are provided the necessary services and opportunities to become productive members of society.

The Epilepsy Foundation of America strongly supports extending Public Law 94-142 mandate to the age of 3. We have long been committed to the goal that children with epilepsy have access to comprehensive early intervention services. We applaud the Senate for enacting S. 2294 and urge you to take prompt action on this initiative so that we can ensure that our children are afforded the maximum opportunity to achieve their full potential.

On behalf of the Foundation and all parents of infants and children with epilepsy, I can ask for no less.

Thank you for this opportunity to present the Epilepsy Foundation of America's views on these crucial issues. We look forward to offering any assistance you may request.

It's been a pleasure to meet each of you.

Mr. WILLIAMS. Thank you.

[The prepared statement of Ann Kinkor follows:]

STATEMENT
RESPECTFULLY SUBMITTED
TO THE
SELECT EDUCATION SUBCOMMITTEE
OF THE HOUSE COMMITTEE ON EDUCATION AND LABOR
ON
S. 2294
EDUCATION OF THE HANDICAPPED ACT AMENDMENTS OF 1986

On Behalf of

EPILEPSY FOUNDATION OF AMERICA

PRESENTED BY: ANN KINKOR

JULY 29, 1986

Mr. Chairman and members of the Subcommittee, my name is Ann Kinkor from Los Angeles County. Two of my four sons have epilepsy. Kevin developed epilepsy when he was three years old. He is now ten and is the Epilepsy Foundation's national Poster Child for 1986. Patrick, age eleven, has experienced seizures for the past two years.

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The Epilepsy Foundation represents a broad spectrum of children who attend either regular education classes, remedial education or special education classes. In special education children with seizures can be found in classes for those who have learning, physical, behavioral, mental, and sensory disabilities. Many of the children in special education classes might be in regular education classrooms if intervention had been available to them at an early age or at the onset of their seizure disorder.

Epilepsy is a collection of symptoms, called seizures, which are the outward signs of a temporary and sudden disturbance in the normal pattern of electrical activity of the brain. Epilepsy takes on many forms, many of which are not easily identified. Many, in fact, do not involve convulsive seizures. My son Kevin has atypical absence seizures, one of the most common forms of epilepsy in young children. These seizures are often mistaken for daydreaming, inattentiveness, or lack of intelligence.

As I mentioned, Kevin began having seizures when he was three. During a seizure, he stares into space for a short period and then falls asleep — his sleep varies — anywhere from five minutes to five hours. Some children have up to two hundred absence seizures per day which have an understandably severe impact on their learning.

My son Patrick has complex partial seizures. His seizure activity begins with a tingling in the left side of his neck and is followed by severe jerking movements on the left side of his body for 15-30 seconds. Sometimes he experiences three or four of these seizures during a 15-20 minute period. Both boys are taking medication which only controls their seizures 85% of the time.

Early intervention and preschool services as provided in S. 2294 are crucial for all infants and young children with seizures and disabilities in general. Seizures in young infants can often be the first indicator that an infant is developing another disabling condition. Deficits such as mental retardation and developmental delay are not uncommon consequences of seizures in early childhood. In addition, the correlation between learning disabilities and seizure disorders is very high. Both disabilities are in many cases related to the same insult to the brain suffered early in life. In addition, repeated seizures and/or the effects of medication can result in the development of learning problems.

I cannot over-emphasize the fact that early intervention and preschool education programs are particularly cost effective for infants and young children with epilepsy. Early intervention can sometimes be sufficient to reverse or ameliorate a child's epilepsy, which might otherwise become a life-long disability. In addition early intervention may eliminate ten to fifteen years of special education later in life.

Furthermore, the need for related services such as speech and language therapy, adaptive physical education, counseling and close medical monitoring by school personnel could often be reduced or eliminated if children were provided comprehensive early intervention and preschool education services.

The cost of these related services increases as a child grows up. Thus, in the long run, the programs provided for in S. 2294 will save millions of dollars each year in special education costs, let alone the costs of emotional stress that children with epilepsy and their families often face.

My son Kevin's experiences illustrate this point. He was diagnosed at age three as having auditory memory problems related to his epilepsy, as well as gross and fine motor problems. He did not receive comprehensive therapy to remedy these problems because we could not afford the only available services. Our insurance plan did not not cover these services and we were not eligible for Medicaid.

Kevin did not begin speech and language therapy until he was in first grade, when he was identified as needing special education services. At that time he needed speech and language services three times per week. He has continued to need this service for the past five years. His gross and fine motor abilities were one to two years behind grade level in the first grade and he has needed adaptive physical educational services three times per week for the past five years as well.

He also needed school counseling for five years to help him with the psycho-social problems he developed as a result of having seizures since early childhood. In addition, Kevin needed close medical monitoring because his seizures were not effectively controlled.

All of the related services that Kevin has required in elementary school and will probably need through his intermediate and high school years might not have been necessary if he had received a comprehensive preschool education program at the time he was identified as having epilepsy.

Kevin's problems are typical of many children with seizures. However, many other young children experience more severe learning disabilities as well as psychological and behavioral disorders which often require placement in residential treatment programs.

If these children with severe deficits due to epilepsy had received early intervention services as infants and preschoolers, their treatment program might have required less intensive remediation — that is, many could be placed in special education classes in public school rather than in an institutional setting and many more could have benefitted only from remedial education services.

As a representative of the Epilepsy Foundation of America and as a parent, I cannot over-emphasize the need for counseling and family support services for families of infants and children with epilepsy. The understanding and acceptance of parents and siblings are crucial to a child's ability to cope with his seizure disorder. Common family reactions to epilepsy range from rejection to overprotection. These reactions can be more damaging to a child's emotional well being than the epilepsy itself. And, the psychological scars left by these reactions often follow a child throughout his/her life and prevent him/her from becoming an independent, contributing member of society.

During the past year, while Kevin has been EFA's national poster child, I have received hundreds of letters and phone calls from parent of infants and young children who have epilepsy. All of these parents have told me of the stress and struggle they have experienced in coping with their child's epilepsy and the tremendous impact their child's seizures have had on their lives.

All parents of children with epilepsy, especially parents of small children, live in day to day fear of their child injuring him/herself during a seizure. Can you imagine what it is like for a parent to watch their child have seizure while learning to walk?

Many parents of preschool children have told me of the emotional harassment their children experience in school. Several parents reported that they had to remove their children from private preschool programs because of the child's seizures.

All of these tensions create great stress in family life. These parents are all struggling to provide their children with opportunities for growth and development and to maintain harmony in the family unit.

My husband and I have exhausted our savings to provide our two children with adequate medical, counseling and educational services. We have been fortunate to be able to do this. However, we are an exception. Most families of children with epilepsy are not able to provide their infants and young children with the services they need.

If children with epilepsy do not receive the early intervention and preschool education services they need during the most crucial years of their development, it is likely that they will experience difficulty in school and in the job market later on. Becoming a productive member of society will be a dream, not a reality for many of these children, unless early intervention services are provided.

Parents of children with disabilities across the country look to the federal government for leadership to ensure that their children are provided the necessary services and opportunities to become productive members of society.

The Epilepsy Foundation of America strongly supports extending the P.L. 94-142 mandate to the age of three. We have long been committed to the goal that children with epilepsy have access to comprehensive early intervention services. We applaud the Senate for enacting S. 2294 and urge you to take prompt action on this initiative so that we can ensure that our children are afforded the maximum opportunity to achieve their full potential. On behalf of the Foundation and all parents of infants and children with epilepsy, I can ask for no less.

Thank you for this opportunity to present the Epilepsy Foundation of America's views on these crucial issues. We look forward to offering any assistance you may request.

Mr. WILLIAMS. Liz Vincent is the President of the division of Early Childhood and is here representing that group, as well as the Association for the Severely Handicapped, and Interact.

We're happy to have you with us today, and you may proceed.

TESTIMONY OF LIZ VINCENT, PRESIDENT, DIVISION OF EARLY CHILDHOOD

Ms. VINCENT. Thank you for the opportunity to present testimony. It's a very rare opportunity to represent three organizations, particularly three organizations that are not noted for often being in agreement on their views.

The Division for Early Childhood [DEC], INTERACT, and TASH are pleased to have the opportunity to convey our views regarding S. 2294, the Education of the Handicapped Amendments of 1986. DEC is a division of the Council for Exceptional Children [CEC], a major national organization representing nearly 50,000 professionals who work with exceptional students of all ages. CEC has already provided testimony to this committee and we wish to voice our strong agreement with key issues and recommendations they offered. DEC has over 4,000 members whose primary professional responsibilities and commitments are to the provision of high quality services to young children with special needs and their families. INTERACT is a national organization of over 1,000 early intervention advocates and professionals who are concerned with providing comprehensive services to infants with special needs and their families. TASH is a national organization of over 6,000 professionals and parents whose primary interests are in the areas of research and quality services for persons with severe handicaps from birth to death.

We appreciate the opportunity to provide input on S. 2294 and applaud your efforts and willingness to undertake deliberations related to the early childhood portions of these amendments during these difficult economic times. Such willingness is consistent with your historical support of programs for young children and their families which dates back to the inclusion in 1969 of Part C of EHA, section 623, i.e., the Handicapped Children's Early Education Program. We will respond primarily to the issues related to what constitutes quality services for young children with special needs and their families and how S. 2294 addresses these issues adequately or needs to be revised.

There are four primary reasons for intervening early with an exceptional child. Intervention enhances children's development. Families receive needed support and assistance. Children and their families are more successful in their communities. Services provided early are less costly than those in the long run.

Early, quality intervention has been demonstrated to result in improvement in the development and learning of children with disabilities and those who have a high risk for developing disabilities. In addition these children need less intense special education services during their school age years, thereby reducing the long term costs for their education. Families of these children report reduced stress and better community integration as a result of early intervention.

Early intervention legislation is needed at this time in order to expand the services available in many states. Previous initiatives, e.g. Public Law 94-142 and 98-199, have been encouraging and permissive in nature as related to serving young at-risk children or children with disabilities. States have had the authority to decide whether to make free and appropriate services available. Approximately half the states have chosen not to do so for children between the ages of 3 and 5 years of age and over three quarters have chosen not to do so for children from birth to 2. S. 2294 contains initiatives which will override the reluctance to serve the 3- to 5-year-old children and further incentives to serve the younger children. S. 2294 contains adjustments to Public Law 94-142 which are needed to effectively serve the 3- to 5-year-old children. We agree with these adjustments in principle, but have some reservations, changes and additions. The rights and protections of Public Law 94-142 should also be extended to the birth through age 2 group of children as well as due process, least restrictive environment, and individualized programs. S. 2294 deals with these issues through the creation of a new initiative for infants and toddlers. Again, we agree in principle with the program which is created, but have suggestions for additions and changes. We will present our recommendations in two subsections.

On services for children birth through 2 years of age. Legislation which deals with the creation of a service delivery system for children under 3 years of age who are displaying risk factors or disabilities must deal with at least six major areas, which are: definition of the children to be served, assurance of a family focus and family involvement, definition of comprehensive services, assurance of interagency coordination, provision of a variety of services, and provision for personnel training and development.

Three groups of young children have been identified as benefiting from early intervention services. These are children who display handicaps or developmental delays, children who have medical or biological factors which put them at risk for becoming handicapped, and children who are living in environments which put them at risk for becoming handicapped.

Children who display handicaps include those with congenital disorders, sensory impairments, neurological dysfunctions or significant delays in one or more of the major areas of development, i.e., cognitive, social/emotional, self-help, language or motor. Medically or biologically at risk children include those for whom early health factors are known to be a potential threat to their successful development. The most numerous of these are babies who are significantly premature at birth, small for gestational age or born to mothers who are chemically dependent or have abused alcohol during pregnancy. Young children who are emotionally at risk are those whose post-natal physical or social environment poses a threat to their successful development. These include children who are abused or neglected, whose parents have been diagnosed as mentally ill or developmentally disabled or who for other reasons are living with parents who are not able to adequately care for them, such as drug or alcohol abusers or pre-teenage parents.

Let me clearly state that in writing a definition of the infants who should be served, the subcommittee should not use any type of categorical definition as is now contained in EHA, mentally retarded, learning disabled, etc.; these are often not appropriate for children under 3 years of age. The rapid growth and change which can occur during the earlier years does not match the characteristics upon which the EHA categorical definitions were developed. The clinically demonstrable discrepancies implied in these definitions are not applicable in the assessment of infants.

We recommend classification of eligibility of children under 3 years of age, must include the three groups of children I described. Environmental risks are not less significant than medical risks. In speaking for three different organizations, let me point out that the TASH population would normally fall within my first definition of infants who are clearly very seriously involved, while the DEC/INTERACT population covers all three. However, TASH joins DEC and INTERACT in supporting a broader definition. The interagency council outlined in S. 2294 should be given the authority to develop a statement of eligible children on a State basis. S. 2294 needs to be expanded to include the at-risk population. The term "substantial" should be removed from defining developmentally delayed. Again, the interagency council should be given the responsibility of defining what constitutes developmental delay needing intervention given the characteristics of their State. Basically, we agree with S. 2294's noncategorical approach, but would recommend broadening the eligible population.

For assurance of a family focus and family involvement, early intervention would result in programs being created which recognize the diverse and often unique needs and resources of families with young children who are at risk or who display developmental delays. The family plays a primary role in the development of the young child. The family is the primary environment and teacher. Consequently, successful development and life outcome are most likely to occur when the family is able to provide such an environment which is supportive and nurturing. The related needs of families often influence their ability to provide such an environment and provisions to assist them in meeting these needs must be included in the intervention program. Where appropriate, family needs should be addressed through the child's written and individualized service program. Parents and professionals need to tunction in a collaborative fashion. Such collaboration serves to support the child while helping the family as a whole cope with its daily stresses in an adaptive manner.

We recommend that the needs and resources of the family should be recognized and included as part of the child's written individualized service program. S. 2294 embodies this recommendation. We would suggest that the same concept embodied in Public Law 94-142 for due process for parents be added to the Senate bill. The systems designed in S. 2294 should be the responsibility of the interagency councils. Currently, States which are serving the birth through age 2 population have evolved a variety of effective procedures for due process.

In the definition of comprehensive services. Effective early intervention programs involve a range of services which are selected on an individual basis to meet the needs of the young child and his/her family. These services include identification, screening, diagnostic evaluation and assessment, medical and health management, developmental and educational services, supportive services for family members and specific therapies and related services. All children and families do not need all services or the same intensity of any of the services. In order for families to receive services which are available they must know that services exist and how to access them. Thus, Child Find is an essential ingredient in comprehensive service delivery. Once a parent and child enter the service delivery system, services need to be delivered in a coordinated fashion and parents need to be decisionmakers in this process.

We recommend that those services which are directly related to alleviating the impact ot a child's handicap or risk factor on the child's or the family's functioning should be the responsibility of the early intervention process. Other services should be available and coordinated with appropriate community agencies. We agree with the principle contained in S. 2294 and voiced in CEC's testimony that EHA money should be the money of last resort. The services necessary to meet the unique developmental needs of the child and support needs of the family should be contained in the written individualized service program. We believe that stronger requirements for Child Find activities should be added to S. 2294.

Assurance of interagency coordination exists when there is a system of multiagency planning and provision of services. Such an approach makes maximal use of community resources and reduces duplication of services. An interagency approach requires that the planners address the process of coordination of services and resources among State and local agencies. To be most effective, a lead agency should be designated to assume responsibility for administering the early intervention program. This concept is equally appropriate for Federal programs, Statewide service delivery systems, local programs or for helping an individual family at the community level. The responsibility should be determined by a council made up of the relevant agencies.

We recommend that the provisions of the Senate bill require that each State appoint an interagency council for early intervention services. We also strongly support the provision which requires the designation of a lead agency to coordinate the planning, implementation and funding of services. This agency needs to insure interagency coordination at the state and community level. As stated previously, we believe that EHA dollars should be of last resort in the process of planning and implementing interagency services.

Providing for a variety of services results in a broad range of options in the least restrictive environment appropriate for each child. These services may range from residential placement to a single consultation. They include, but are not limited to, hospital based, center based, home based, day care, Head Start, mainstreamed nursery programs, related services and therapies, and family support and education. No single system of service delivery is appropriate to all agencies or to all children and families. The effectiveness of a wide variety of theoretical bases and service models has been demonstrated.

We recommend that States offer a sufficient variety of services within the community so that services are responsive to the needs of the individual children and their families. The language in S.

2294 needs to be strengthened to more fully convey the range of services necessary.

About provision for personnel training and development. Both preservice and inservice training efforts are needed to adequately prepare and maintain qualified personnel for early intervention years. Early intervention programs require personnel who are trained in a variety of disciplines and in early intervention practices. The need for training programs cuts across all levels of personnel; from volunteers and paraprofessionals to the professional staff. The professional personnel may include physicians, nurses, occupational and physical therapists, special and regular educators, psychologists, social workers, speech and language pathologists, and administrators.

Training of a cadre of quality early childhood professionals constitutes one of the largest areas of need in personnel development. Not only is there a shortage of personnel, but individuals who are currently working with young children are often not trained to meet their unique developmental needs or those of the family. It is our strong feeling that without leadership from the Federal Government, the Nation's infants will continue to be served by people who are sometimes not trained or skilled in this area. Just as Public Law 94-142 opened the door for quality personnel preparation for the school age child with handicaps, we feel this bill will do the same for infant personnel.

We recommend that each State, through the interagency council, should set standards, address issues of licensure and certification, and make provision for pre- and inservice training. Federal programs should be continued, and in some respects, enhanced, which support the training of early intervention personnel and which provide technical assistance in a variety of models of services.

We recommend that each State, through the interagency council, should set standards, address issues. Also, the current Handicapped Children's Early Education Program [HCEEP] demonstration and outreach programs are important examples of such technical assistance resources for States and communities. States should be encouraged and supported in the development of a State level training and technical assistance office to match local program needs with resources at the Federal, regional, State and local levels. We strongly recommend the continuation of the HCEEP demonstration, outreach, and State planning efforts. We recommend that technical assistance be available to these demonstration and outreach projects so as to assure that high quality models and training sites are available on state and local levels. We are concerned by the U.S. Department of Education, Office of Special Education Program's recent decision to cease the provision of technical assistance to the demonstration and outreach projects. We support the provision in S. 2294 for the provision of technical assistance to early intervention programs. We also support the continuation of the early childhood priority in the EHA, part D. These personnel preparation programs are helping states to develop high quality preservice training programs in the area of infant intervention.

Finally, on children 3 through 5 years of age. Present legislation (Public Law 94-142) provides a structure for educating handicapped children ages 3 through 5 that is similar to that used for school aged children. This structure includes critically important elements such as due process, Child Find, individualized educational programs, and least restrictive environment. S. 2294 mandates that this structure will be for the 3 through 5 year old child. We totally support this mandate. However, to meet the unique needs of the 3 through 5 year old population, a minimum of two adjustments to the current provisions is needed.

We recommend, first, that the family focus which was described earlier be added to the provisions for the 3 to 5 year old children's programs. Parents as essential collaborators and the ability to include services to parents as part of the written individualized educational program are necessary.

Second, to avoid the premature labeling of young children, a noncategorical classification should be added to the current Federal law. We would suggest that the category "developmentally delayed," which is contained in S. 2294, would be appropriate.

Finally, Mr. Chairman, I would like to address a philosophical question that I understand this subcommittee has been grappling with during these meetings: The appropriate role of the Federal Government in the provision of services to infants and young children with handicaps.

I don't believe there is any doubt in this subcommittee or in the Nation as a whole that the Federal leadership and funding as defined in 94-142 is appropriate. Public Law 94-142 had its basis in the professional recognition that educational services were possible for all children, regardless of a handicapping condition. Thus the Federal Government guaranteed free educational services to children with handicaps.

By further adopting the term appropriate in Public Law 94-142, the Federal Government provided an extra umbrella of protection for children with handicaps—a protection not afforded their peers without handicaps.

Without these protections few would have believed possible the advances and improvements in the independence and quality of life for individuals with handicaps, both in childhood and throughout their lives.

We now know through advanced medical, technological, educational and developmental research and practice that early intervention services can result in equally astounding improvements or eliminations of handicapping conditions. However, many infants who could benefit from early intervention are not receiving the full range of services. Extra protections from the Federal Government are needed and appropriate for this population just as they are with school age children and youth to ensure service delivery.

Strong leadership is needed from this subcommittee to pass a bill this year in the House of Representatives in behalf of infants and young children with handicaps. I urge you to take this on as your major priority for the rest of this legislative year.

We believe that S. 2294 provides a good start toward creating a more effective system of services for young exceptional children and their families. We look forward to working with you to improve, refine, and expand its provisions so that we can conclude this session with new commitment to early intervention.

Mr. **Williams**. Thank you.

[The following was received for the record:]

STATEMENT OF THE DIVISION FOR EARLY CHILDHOOD OF THE COUNCIL FOR EXCEPTIONAL CHILDREN

AND

INTERACT - THE NATIONAL COMMITTEE FOR YOUNG CHLILDREN WITH SPECIAL NEEDS AND THEIR FAMILIES

AND

THE ASSOCIATION FOR PERSONS WITH SEVERE HANDICAPS

TO

THE SUBCOMMITTEE ON SELECT EDUCATION OF
THE U.S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO
S. 2294 - THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

July 29, 1986

Submitted by:

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Mr. Chairman and Members of the Subcommittee:

The Division for Early Childhood (DEC), INTERACT, and TASH are pleased to have the opportunity to convey our views regarding S. 2294, the Education of the Handicapped Amendments of 1986. DEC is a division of the Council for Exceptional Children (CEC), a major national organization representing nearly 50,000 professionals who work with exceptional students of all ages. CEC has already provided testimony to this committee and we wish to voice our strong agreement with key issues and recommendations they offered. DEC has over 4,000 members whose primary professional responsibilities and commitments are to the provision of high quality early intervention services to young children with special needs and their families. INTERACT is a national organization of over 1,000 early intervention advocates and professionals who are concerned with providing comprehensive services for infants with special needs and their families. TASH is a national organization of over 6,000 professionals and parents whose primary interests are in the areas of research and quality services for persons with severe handicaps from birth to death.

We appreciate the opportunity to provide input on S. 2294 and applaud your willingness to undertake deliberations related to the early childhood portions of these amendments during these difficult economic times. Such willingness is consistent with your historical support of programs for young children and their families which dates back to the inclusion in 1969 of Part C of EHA, Section 623, i.e., the Handicapped Children's Early Education Program. We will respond primarily to the issues related to what constitutes quality services for young children with special needs and their families and how S. 2294 addresses these issues adequately or needs to be revised.

There are four primary reasons for intervening early with an exceptional child: intervention enhances children's development; families receive needed support and assistance; children and their families are more successful in their communities; and services provided early are less costly in the long run.

Early, quality intervention has been demonstrated to result in improvement in the development and learning of children with disabilities and those who have a high risk for developing disabilities. In addition, these children need less intense special education services during their school age years, thereby reducing the long term costs for their education. Families of these children report reduced stress and better community integration as a result of early intervention.

Early intervention legislation is needed at this time in order to expand the services available in many states. Previous initiatives, e.g., P.L. 94-142 and 98-199, have been encouraging and permissive in nature as related to serving young at-risk children or children with disabilities. States have had the authority to decide whether to make free and appropriate services available. Approximately half of the states have chosen not to do so for children between three and five years of age and over three quarters have chosen not to do so for children birth through two years of age. S. 2294 contains initiatives which will override the reluctance to serve the three to five year old children and further incentives to serve the younger children. S. 2294 contains adjustments to P.L. 94-142 which are needed to effectively serve the three to five year old children. We agree with these adjustments in principle, but have some suggested changes and additions. The rights and protections of P.L. 94-142 should also be extended to the birth through age two group of children as well, i.e., due process, least restrictive environment, and individualized programs. S. 2294 deals with these issues through the creation of a new initiative for infants and toddlers. Again, we agree in principle with the program which is created, but have suggestions for additions and changes. We will present our recommendations in two subsections.

SERVICES FOR CHILDREN BIRTH THROUGH TWO YEARS OF AGE

Legislation which deals with the creation of a service delivery system for children under three years of age who are displaying risk factors or disabilities must deal with at least six major areas. These are: 1) definition of the children to be served; 2) assurance of a family focus and family involvement; 3) definition of comprehensive services; 4) assurance of interagency coordination; 5) provision of a variety of services; and, 6) provision for personnel training and development.

Definition of the Children to Be Served

Three groups of young children have been identified as benefiting from early intervention services. These are: children who display handicaps or developmental delays; children who have medical or biological factors which put them at risk for becoming handicapped; and, children who are living in environments which put them at risk for becoming handicapped.

Children who display handicaps include those with congenital disorders, sensory impairments, neurological dysfunctions or significant delays in one or more of the major areas of development, i.e., cognitive, social/emotional, self-help, language or motor. Medically or biologically at-risk children include those for whom early health factors are known to be a potential threat to their successful development. The most numerous of these are babies who are significantly premature at birth, small for gestational age or born to mothers who are chemically dependent or have abused alcohol during pregnancy. Young children who are environmentally at risk are those whose post-natal physical or social environment poses a threat to their successful development. These include children who are abused or neglected, whose parents have been diagnosed as mentally ill or developmentally disabled or who for other reasons are living with parents who are not able to adequately care for them, e.g., drug or alcohol abusers and preteenage parents.

Let me clearly state that in writing a definition of the infants who should be served, the Subcommittee should not use any type of categorical definition as is now contained in EHA, e.g., mentally retarded, learning disabled, etc.; categorical definitions are not appropriate for children under three years of age. The rapid growth and change which can occur during the earlier years does not match the characteristics upon which the EHA categorical definitions were developed. The clinically demonstrable discrepancies implied in these definitions are not applicable in the assessment of infants.

Recommendation. Classification of eligibility of children under three years of age must include the three groups of children described. Environmental risks are not less significant than medical risks. Since I am speaking for three different organizations, I should point out that the TASH population would most likely fall within my first definition of infants who are clearly very seriously involved, while the DEC/INTERACT population covers all three. However, TASH joins DEC and INTERACT in supporting a broader definition. The interagency council outlined in S. 2294 should be given the authority to develop a statement of eligible children on a state-by-state basis within the guidelines outlined above. S. 2294 needs to be expanded to include the at-risk population. Also the term "substantial" should be removed from defining developmentally delayed. Again, the interagency council should be given the responsibility of defining what constitutes a developmental delay needing intervention given the characteristice of their state. Basically, we agree with S. 2294's noncategorical approach, but would recommend broadening the eligible population.

Assurance of a Family Focus and Family Involvement

Early intervention legislation should result in programs being created which recognize the diverse and unique needs and resources of families with young children who are at-risk or who display developmental delays. The family plays a primary role in the development of the young child. The family is the primary environment and teacher. Consequently, successful development and life outcome are most likely to occur when the family is able to provide a supportive and nurturing environment. The related needs of families often influence their ability to provide such an environment and provisions to assist them in meeting these needs must be included in the intervention program. Where appropriate, family needs should be addressed through the child's written individualized service program. Parents and professionals need to function in a collaborative fashion. Such collaboration serves to support the child while helping the family as a whole cope with its daily stressors in an adaptive manner.

Recommendation. The needs and resources of the family should be recognized and included as part of the child's written individualized service program. S. 2294 embodies this recommendation. We would suggest that the same concept embodied in P.L. 94-142 for due process for parents be added to the Senate bill. The systems designed should be the responsibility of the interagency councils designated in S. 2294. Currently, several states which are serving the birth through age two population have evolved a variety of effective procedures for due process.

Definition of Comprehensive Services

Effective early intervention programs involve a range of services which are selected on an individualized basis to meet the unique needs of the young child and his/her family. These services include identification, screening, diagnostic evaluation and assessment, medical and health management, developmental and educational services, supportive services for family members and specific therapies and related services. All children and families do not need all services or the same intensity of any of the services. In order for families to receive services which are available they must know that services exist and how to access them. Thus, Child Find is an essential ingredient in comprehensive service delivery. Once a parent and child enter the service delivery system, services need to be delivered in a coordinated fashion and parents need to be decision-makers in this process.

Recommendation. Those services which are directly related to alleviating the impact of a child's handicap or risk factor on the child's or the family's functioning should be the responsibility of the early intervention program. Other services should be available and coordinated with appropriate community agencies. We agree with the principle contained in S. 2294 and voiced in CEC's testimony that EHA money should be the money of last resort. The services necessary to meet the unique developmental needs of the child and support needs of the family should be contained in the written individualized service program. We believe that stronger requirements for Child Find activities should be added to S. 2294 activities should be added to S. 2294

Assurance of Interagency Coordination

Interagency coordination exists when there is a system of multi-agency planning and provision of services. Such an approach makes maximal use of community resources and reduces duplication of services. An interagency approach requires that planners address the process of coordination of services and resources among state and local agencies. To be most effective, a lead agency should be designated to assume responsibility for administering the early intervention program. This concept is equally appropriate for federal programs, state wide service delivery systems, local programs or for helping an individual family at the community level. The responsibility for due process should be determined by a council made up of the relevant agencies.

Recommendation. We strongly support the provisions of the Senate bill which require that each state appoint an interagency council for early intervention services. We also strongly support the provision which requires the designation of a lead agency to coordinate the planning, implementation and funding of services. This agency needs to insure interagency coordination at the state and community level. As stated previously, we believe that EHA dollars should be of last resort in the process of planning and implementing interagency services.

Provision of a Variety of Services

Providing for a variety of services results in a broad range of options in the least restrictive environment appropriate for each child. These services may range from alternative home placement to a single consultation. They include, but are not limited to, hospital based, center based, home based, day care, Head Start, mainstreamed nursery programs, related services and therapies, and family support and education. No single system of service delivery is appropriate to all agencies or to all children and families. The effectiveness of a wide variety of theoretical bases and service models has been demonstrated.

Recommendation. States should offer a sufficient variety of services within the community so that services are responsive to the needs of individual children and their families. The language in S. 2294 needs to be strengthened to more fully convey the range of services necessary.

Provision for Personnel Training and Development

Both preservice and inservice training efforts are needed to adequately prepare and maintain qualified personnel for early intervention programs. Early intervention programs require personnel who are trained in a variety of disciplines and in early intervention practices. The need for training cuts across all levels of personnel; from volunteers and paraprofessionals to the professional staff. Professional personnel may include physicians, nurses, occupational and physical therapists, special and regular educators, psychologists, social workers, speech and language pathologists, and administrators.

Training of a cadre of quality early childhood professionals development. Not only is there a shortage of personnel, but individuals who are currently working with young children are often not trained to meet their unique developmental needs or those of their family. It is our strong feeling that without leadership from the federal government, the nation's infants will continue to be served by people who are sometimes not trained or skilled in this area. Just as P.L. 94-192 opened the door for quality personnel preparation for the school age child with handicaps, we feel this bill will do the same for infant personnel.

Recommendation. Each state, through the interagency council, should set standards, address issues of licensure and certification, and make provision for preservice and inservice training. Federal programs should be continued, and in some respects, enhanced, which support the training of early intervention personnel and which provide technical assistance in a variety of models of services.

The current Handicapped Children's Early Education Program (HCEEP) Demonstration and Outreach programs are important examples of such technical assistance resources for states and communities. States should be encouraged and supported in the development of a state level training and technical assistance office to match local program needs with resources at the federal, regional, state, and local levels. We strongly recommend the continuation of the HCEEP Demonstration, Outreach, and State Planning efforts. We recommend that technical assistance be available to these Demonstration and Outreach projects so as to assure that high quality models and training projects so as to assure that high quality models and training sites are available on state and local levels. We are concerned by the U.S. Department of Education, Office of Special Education Programs' recent decision to cease the provision of technical assistance to Demonstration and Outreach projects. We support the provision in Senate Bill 2294 for the provision of technical assistance to early intervention programs. We also support the continuation of the early childhood priority in the EHA, Part D. These personnel preparation programs are helping states to develop high quality preservice training programs in the area of infant intervention.

CHILDREN THREE THROUGH FIVE YEARS OF AGE

Present legislation (P.L. 94-142) provides a structure for educating handicapped children ages three through five that is similar to that used for school aged children. This structure includes critically important elements such as due process, Child Find, Individualized Educational Programs, and least restrictive environment. S. 2294 mandates this structure for the three through five year old child. We totally support this mandate. However, to meet the unique needs of the three through five year old population, a minimum of two adjustments to current provisions is needed.

Recommendation. First, the family focus which was described in an earlier section needs to be added to the provisions for the three to five year old children's programs. Parents as essential collaborators and the ability to include services to parents as part of the written Individualized Educational Program are

Second, to avoid the premature labeling of young children, a noncategorical classification should be added to the current federal law. We would suggest that the category "developmentally delayed," which is contained in S. 2294, is appropriate.

Finally, Mr. Chairman, I would like to address a philosophical question that I understand this Subcommittee has been grappling with during these hearings: the appropriate role of the federal government in the provision of services to infants and young children with handicaps.

I don't believe there is any doubt in this Subcommittee or in the nation as a whole that the federal leadership and funding as defined in 94-142 is appropriate. P.L. 94-142 had its basis in the professional recognition that educational services were possible for all children, regardless of a handicapping condition. Thus the federal government guaranteed free educational services to children with handicaps.

By further adopting the term appropriate in P.L. 94-142, the Federal government provided an extra umbrella of protection for children with handicaps - a protection not afforded their peers without handicaps.

Without these protections few would have believed possible the advances and improvements in the independence and quality of life for individuals with handicaps, both in childhood and throughout their lives.

We now know through advanced medical, technological, educational, and developmental research and practice that early intervention services can result in equally astounding improvements or eliminations of handicapping conditions. However, many infants who could benefit from early intervention are not receiving the full range of services. Extra protections from the Federal government are needed and appropriate for this population just as they are with school age children and youth to ensure service delivery.

Strong leadership is needed from this Subcommittee to pass a bill this year in the House of Representatives in behalf of infants and young children with handicaps. I urge you to take this on as your major priority for the rest of this legislative year.

SUMMARY

The Division for Early Childhood, INTERACT, and TASH appreciate the opportunity to provide our views to the Subcommittee. We believe that S.2294 provides a good start toward creating a more effective system of service delivery for young exceptional children and their families. We look forward to working with you to improve, refine, and expand its provisions so that we can conclude this legislative session with a new commitment to early intervention.

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THE ARGUMENT FOR EARLY INTERVENTION

What is Early Intervention?

Early intervention means discovering that a child between birth and school age has or is at risk of having a handicapping condition or other special need that may affect his or her development and then providing services to lessen the effects of the condition. Early intervention can be remedial or preventive in nature—remediating existing developmental problems or preventing their occurrance. Early intervention may begin at any time between birth and school age, however, there are many reasons to begin as early as possible.

Why Intervene Early?

There are three primary reasons for intervening early with an exceptional child—to enhance the child's development, to provide support and assistance to the family, and to maximize the child's and family's benefit to society.

Child development research has established that the rate of human learning and development is most rapid in the preschool years. Timing of intervention becomes particularly important when a child runs the risk of missing an opportunity to learn during a state of maximum readiness. If the most "teachable moments" or readiness stages are not taken advantage of, a child may have difficulty learning a particular skill at a later time.

Early intervention services have a significant impact as well for the parents and siblings of an exceptional infant or young child. The family of a young exceptional child often feels disappointment, social isolation, added economic stress, frustration, and helplessness. The compounded stress of the presence of an exceptional child may affect the families' well-being and interfere with the child's development. Families of handicapped children are found to experience increased instances of divorce and suicide, and a handicapped child is more likely to be abused than is a nonhandicapped child. Early intervention for parents results in improved attitudes about themselves and their child, improved information and skills for teaching their child, and more time for both work and leisure. Parents of gifted preschoolers also need early services so that they may better provide the supportive and nourishing environment needed by the child.

A third reason for intervening early is that society will reap maximum benefits. The child's increased developmental and educational gains and decreased dependence upon social institutions, as well as the family's increased ability to cope with the presence of an exceptional child and, perhaps increased ability for employment, provide economic as well as social benefits.

Is Early Intervention Really Effective?

After nearly 50 years of research there is still a great deal to learn. Efforts to document effectiveness have been hindered by experimental design problems associated with low-incidence handicapping conditions, the diversity of children's problems and the limited scope of available assessment instruments. However, even with these problems, there is evidence—both quantitative (data-based) and qualitative (reports of parents, teachers)—that early intervention increases the developmental/educational gains for the child, improves the functioning of the family, and reaps long term benefits to society. Early intervention for handicapped or disadvantaged children has been shown to result in the child's needing fewer special education and other habilitative services later in life, being retained in grade less often, and in some cases, actually being indistinguishable from nonhandicapped classmates years after intervention.

Disadvantaged and gifted preschool-aged children benefit from early intervention as well. Longitudinal data on disadvantaged children who had participated in the Ypsilanti Perry Preschool Project showed that they had made significant gains by age 15 (Schweinhart & Weikart, 1980). These children were more committed to schooling and were doing better in school than children who did not attend preschool. They scored higher on reading, arithmetic, and language achievement tests at all grade levels; showed a 50% reduction in the need for special education services through the end of high school; and showed less anti-social or delinquent behavior outside of school. Karnes (1983) asserts that underachievement in the gifted child may be prevented by early identification and appropriate programming.

Is Early Intervention Cost Effective?

The available data emphasize the *long term* cost effectiveness of early intervention. The highly specialized, comprehensive services necessary to produce the desired developmental gains are often, on a *short term* basis, more costly than traditional school-aged service delivery models. However, there are significant examples of long-term cost savings that result from such early intervention programs.

- A longitudinal study of children who had participated in the Perry Preschool Project (Schweinhart & Weikart, 1980) found that when schools invest about $3,000 for one year of preschool education for a child, they immediately begin to recover their investment through savings in special education services. Benefits included $668 from the mother's released time while the child attended preschool; $3,353 saved by the public schools because children with preschool education had fewer years in special education and were retained for fewer years in grades; and $10,798 in projected life-time earnings for the child.
- Wood (1981) calculated the total cumulative costs to age 18 of special education services to a child beginning intervention at (a) birth, (b) age two, (c) age 6, and (d) at age 6 with no eventual movement to regular education. She found that the total costs were actually less if begun at birth! Total cost of special services begun at birth was $37,273 and total cost if begun at age 6 was between $46,816 and $53,340. The cost is less the earlier the intervention because of the remediation and prevention of developmental problems which would have required special services later in life.
- A three year follow-up in Tennessee showed that for every dollar spent on early treatment, $7.00 in savings were realized within 36 months. This savings resulted from deferral of special class placement and institutionalization for

severe behavior disordered children (Snider, Sullivan & Manning, 1974)

- A recent evaluation of Colorado's statewide early intervention services reports a cost savings of $4.00 for every $1.00 spent within a three-year period (McNulty, Smith & Soper 1983)

Are There Critical Factors That Affect the Success of Early Intervention Programs?

While there have been too few attempts to determine critical features of early intervention programs, there are three recurrent factors present in most effective programs. These include the age of the child at the time of intervention, parent involvement, and the intensity and/or the amount of structure of the program model.

1. Many studies report that the earlier the intervention the more effective. With intervention at birth, or as soon after the diagnosis of a disability as possible, the developmental gains are greatest and the likelihood of developing problems later is reduced. (Garland et al., 1981)
2. The involvement of parents in their child's treatment is also important. The data show that parents of both handicapped and gifted preschool children need the support and skills necessary to cope with their child's special needs. (Beckman-Bell, 1981)
3. Highly structured programs appear to be the most successful (White, 1984). That is, maximum benefits are reported in programs that clearly specify and frequently monitor the child's and family's behavioral objectives, precisely identify teacher behaviors and activities that are to be used in each lesson, utilize task analysis procedures, and regularly use child assessment and progress data to modify instruction. In addition to structure, the intensity of the services, particularly for severely disordered children, can significantly affect outcomes (Lovaas, 1982). Finally, individualizing instruction and services to specifically meet the childs' needs also increases a program's effectiveness.

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Available from The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091-1589 (703/620-3660).

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Mr. **Williams.** Samuel Meisels is with the Center for Human Growth and Development of the University of Michigan, and it's a pleasure to see you here today. Please proceed.

TESTIMONY OF SAMUEL J. MEISELS, PROFESSOR OF EDUCATION AND RESEARCH SCIENTIST, CENTER FOR HUMAN GROWTH AND DEVELOPMENT, UNIVERSITY OF MICHIGAN

Dr. **Meisels.** Thank you very much. I'll try to hold it down to five minutes, if I can.

I'm here to testify in favor of the intent of S. 2294, and to encourage you to amend or rewrite this bill so that it more effectively achieves its objectives. Unlike most of my colleagues here today, my remarks are meant not to represent those of a professional organization—I belong to most of the organizations that are represented here—but to underscore the programmatic and policy oriented components of effective early childhood intervention that my research and that of others has identified.

This research provides extremely strong evidence to support three of the key features of the bill. Those features are: The need for a legislative mandate; the impact of a clearly defined administrative structure; and the importance of a secure fiscal base to support early intervention services.

Let me share with you some aspects of the research that I conducted in the Commonwealth of Massachusetts that illustrates the potential of this bill. Prior to 1983 early intervention services in Massachusetts were characterized by fragmented policy, no overall leadership, and lack of awareness by legislators and State agency officials concerning the importance of the early years of life. To better understand the problems that existed in Massachusetts, I want to focus on those three components of mandate, administration and funding.

First, mandate: Prior to 1983 seven State human service agencies provided services to young handicapped children in Massachusetts. Nineteen different Federal and State laws, statutes or regulations guided these services. There were no due process procedures for families, and State agencies had no obligation to set aside funds for early intervention.

The second set of problems we identified in Massachusetts concerned State level administration. Take my word for it, I can go into it in greater depth and I have in writing, prior to 1983 Massachusetts had no lead administering agency, and it had every conceivable and imaginable administrative problem you can put together, if you have a situation that has no administrative management and control.

The third component concerned fiscal issues. We found that, due to the lack of mandate and administrative lead agency, funding was not embedded in the statutes or regulations. Moreover, local intervention programs had to look to a total of thirty public and private monetary sources to stay afloat. There were many other fiscal problems that were also identified.

These problems are not unique, nor in fact are they unusual. What is unusual is that in Massachusetts something was done about this, whereby a State law was passed in 1983 establishing a legislative mandate for services, a lead administering agency. and a stable fiscal base. But many States throughout the country are in exactly the same situation today that Massachusetts found itself in 1979 when our study began.

Let me tell you a bit now about early childhood services from a national point of view. My colleagues and I have just completed a comprehensive survey research study in which we collected data from the State planning grant directors in all 50 states, the District of Columbia and Puerto Rico.

We identified several critical problems that act as barriers to the provision of effective early childhood intervention services, such barriers as overlapping mandates, low funding levels, inconsistent eligibility criteria, limitations on use of funds, inconsistent regulations, duplication of services, absence of accountability and lack of program evaluation.

These problems, which are nearly identical to the problems existing in Massachusetts prior to their reorganization of services, are exacerbated, if not caused, by problems with mandate, administration, and funding.

In our national study we found that States that do have these features are much more likely to have overall policies and programs that favor disabled young children than those States without these features.

In short, the evidence needed to support this or a related bill exists already, but I'd like to recommend three points having to do with the components that I've been talking about today.

First, the mandate: I believe that it should be clearly defined, as you have or as is in S. 2294, for 3 to 5 year olds, as a child based entitlement. But birth to 3 year olds are treated too vaguely in the bill. I'd like to recommend that a legislative mandate be enacted to provide for the establishment of at least a limited number of demonstration programs in every State, so that at least some birth to 3 year olds are mandated and guaranteed to receive services, and so that incentives are made available to serve larger numbers.

The second issue concerns administrative leadership, and it relates to the questions that were asked of the first panel.

I believe that those should be so amended that it maintains a clear identity for early childhood developmental services within the lead administering agency. Handicapped infants and preschoolers and their families require policies, procedures, services, personnel and regulations that differ from those prescribed for school age children.

Thus, I strongly recommend that the lead administering agency be directed to establish a distinct early childhood unit, this unit responsible for the implementation of the early childhood amendments included in this bill.

Finally, the issues of funding, of course, must be addressed. Without adequate new funding of as much as 50 percent of the cost of proposed mandated services, the States will strongly object to this bill, and the probability of its successful implementation is greatly reduced.

To summarize, the mandate is a necessary but not sufficient condition for the establishment of humane and effective early childhood intervention services. Needed also are provisions for a distinct set of early childhood, not diluted school age, practices, procedures, personnel and policies located within a clearly identifiable early childhood intervention administering agency, along with a realistic estimate of cost of funding these critically important programs.

We no longer need, as everyone is telling you, to ask the question "Is early intervention effective?" Rather, today's question, I believe, is "How can we distribute effectively early intervention services to every handicapped child in this country?"

We look to your leadership in Congress to fashion an equitable response to this most urgent concern.

[The prepared statement of Samuel J. Meisels follows:]

Testimony of Samuel J. Meisels, Ed.D., of the University of Michigan Before the Subcommittee on Select Education Regarding S. 2294, The Education of the Handicapped Amendments of 1986.

July 29, 1986

I am here to testify in favor of the intent of S. 2294, and to encourage you to amend or rewrite this Bill so that it more effectively achieves its objectives. My remarks are not designed to represent the point of view of a particular organization or group of professionals, but to underscore the programmatic and policy-oriented components of effective early childhood intervention that my research and that of others has identified. I will first discuss my reasons for urging that this Bill, or one similar to it, be passed by this subcommittee; second, I will note those aspects of the Bill in need of revision or amendment.

Research that I completed in Massachusetts, as well as data I and my colleagues recently collected from all 50 states, the District of Columbia and Puerto Rico provides extremely strong evidence to support 3 of the key features of this Bill. Those features are 1) the need for a legislative mandate; 2) the impact of a clearly defined administrative structure; and 3) the importance of a secure fiscal base to support early intervention services.

Let me share with you some aspects of the research that I conducted in the Commonwealth of Massachusetts--research that illustrates the potential of this Bill (see Meisels [1985] for a complete account of the Massachusetts situation). Prior to 1983 early intervention services in Massachusetts were characterized by fragmented policy, no overall leadership, and lack of awareness by legislators and state agency officials concerning the educational and developmental importance of the early years of life. The responsibility for early childhood intervention services was distributed among too many agencies in too many different ways with too little administrative, policy, and fiscal direction.

To better understand the problems that existed in Massachusetts I want to focus on the 3 components I mentioned earlier: mandate, administration, and funding. First, mandate: prior to 1983, because of the absence of a clear mandate, 7 state human service agencies provided services to young handicapped children in Massachusetts. Nineteen different federal and state laws, statutes, or regulations guided these services. Moreover, there were no due process procedures for families, and state agencies had no obligation to set aside funds for early intervention. Thus, the absence of a mandate contributed in a number of significant ways to a lack of statewide coordination of services to disabled young children and their families.

The second set of problems we identified in Massachusetts concerned state-level administration. We found the following: inconsistent communication within and between state agencies; inconsistent reporting and data collection procedures; lack of common evaluation and monitoring processes to determine the efficacy of both procedures and programs; sparse provision of technical assistance to service providers; and confusion regarding overlapping responsibilities of state agencies. In brief, prior to 1983 Massachusetts had no lead administering agency for early intervention services, and it had virtually every imaginable problem associated with the absence of administrative management and control.

The third component I want to address today concerns fiscal issues. In our study of Massachusetts we found that, due to the lack of mandate and administrative lead agency, funding was not embedded in statutes or regulations. Moreover, local intervention programs had to look to a total of more than 30 public and private monetary sources to stay afloat. Other fiscal concerns included: inadequate funds for appropriate physical space, for fair market wages, and for support of professional growth; and problems with third party reimbursements as well as general fiscal instability.

The problems and issues I have just enumerated are not unique or unusual. What is unusual is that Massachusetts did something about these problems, passing a state law (Chapter 699) in 1983 that established a legislative mandate for services, a lead administering agency, and a stable fiscal base to support early intervention services. But many states throughout the country are in exactly the situation today that Massachusetts was in in 1979 when our study began. Today only 8 states have mandated services that begin at birth and another 13 states and the District of Columbia mandate services by age 3. But 24 states still have no legislative mandate before age 5.

Let me tell you a little more about early childhood special education services from a national point of view. My colleagues and I have just completed a comprehensive survey research study in which we collected data from the state planning grant directors in all 50 states, the District of Columbia, and Puerto Rico. We identified several critical problems that prove to be barriers to the provision of effective early childhood intervention services. Specifically, state planning grant directors most frequently mentioned the following problems:

1. Overlapping mandates
2. Low funding levels
3. Inconsistent eligibility criteria
4. Limitations on use of funds
5. Inconsistent regulations
6. Duplication of services
7. Absence of accountability
8. Lack of program evaluation

These problems, which are nearly identical to the problems existing in Massachusetts prior to their reorganization of services, are exacerbated--if not caused--by problems with mandate, administration, and funding.

In our national study we found that the vast majority of the states that had child-based entitlements or legislative mandates were ranked among the top 10 states in our research in terms of range of handicapping conditions served, types of intervention services provided, availability of funding sources, extent of interagency contacts, and existence of early childhood regulations and guidelines. In other words, states with mandates, lead administering agencies, and fiscal support for early intervention services are much more likely to have overall policies and programs that favor disabled young children than those states without these features.

In short, the evidence needed to provide for this or a related Bill exists already. States that today come closest to matching the proposed regulations of S. 2294--and there are only 6 or 8 such states--are those states with the best services and fewest system-wide problems in the country. In contrast, those states farthest from the intent of S. 2294 are delivering the fewest services amidst the most frustrating of circumstances for families, providers, and state- and local-level officials.

However, I want to encourage you to focus great care on the 3 components I have been discussing today. First, the mandate should clearly be described as a child-based entitlement for all disabled children, as it currently is proposed for 3-5 year olds. But birth to 3-year olds are treated too vaguely in the Bill. I would like to recommend that a legislative mandate be enacted to provide for the establishment of at least a limited number of demonstration programs in every state so that at least some birth to 3-year olds receive services, and so that incentives are made available to serve larger numbers.

The second issue concerns administrative leadership. The Bill should be so amended that it maintains a clear identity for early childhood developmental services within the lead administering agency. Handicapped infants and preschoolers and their families require policies, procedures, services, personnel, and regulations that differ from those prescribed for school-age children. Thus, I strongly recommend that the lead administering agency be directed to establish a distinct early childhood unit, this unit responsible for the implementation of the early childhood amendments included in this Bill.

Finally, the issues of funding must be addressed. Without adequate new funding of as much as 50% of the cost of proposed mandated services the states will strongly object to this Bill, and the probability of its successful implementation is greatly reduced. In a continuing era of budget shortfalls and deficit reduction one must, of course, question the appropriateness of new funds for an additional population. Yet, the benefit-cost analyses that have focused on early childhood intervention strongly support the wisdom of this initial investment in terms of the long-term gains for individuals and society. Given the logic of this argument the appropriation for birth to 3-year olds in S. 2294 appears particularly inadequate and in need of supplementary funds.

To summarize, a mandate is a necessary but not sufficient condition for the establishment of humane and effective early childhood intervention services. Needed also are provisions for a distinct set of *early childhood* --not diluted school-age-- practices, procedures, personnel, and policies located within a clearly identifiable early childhood intervention administering agency. Also needed are realistic estimates of the cost of funding these critically important programs.

We are no longer trying to answer the question "Is early intervention effective?" Numerous studies have provided an affirmative answer to this question (see Meisels, 1985b). Today we are posing a different question, namely, "How can we distribute effective early intervention services to every handicapped child in this country?" We look to your leadership in Congress to fashion an equitable response to this most urgent concern.

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Mr. WILLIAMS. Thank you very much.

Mr. Henry Tecklenburg was unable to be with us today. We have Mr. David Davis representing the Alexander Graham Bell Association for the Deaf.

TESTIMONY OF DAVID DAVIS, ALEXANDER GRAHAM BELL ASSOCIATION FOR THE DEAF

Mr. DAVIS. Thank you.

Mr. Chairman, on behalf of the Alexander Graham Bell Association for the Deaf, I would like to open by thanking you for the opportunity to speak before your subcommittee regarding the importance of early identification and intervention programs. Your willingness to address this issue is greatly appreciated.

My name is David Davis. I am 21 years old and will be a senior at Harvard University this fall. Part of my education is funded through scholarship from the Alexander Graham Bell Association for the Deaf. I am also currently a summer intern at the Association and have firsthand experience with the importance of early intervention and identification programs. For you see, I have a profound hearing loss.

I am here on behalf of the Alexander Graham Bell Association to discuss the need to inform parents, educators and physicians of the importance of early identification and intervention programs. Our experience with our own Hearing Alert Program has taught us that these programs provide the foundation for succesful mainstreaming of deaf children.

As some of you may know, the Alexander Graham Bell Association for the Deaf was founded in 1890 by Alexander Graham Bell to ensure that every deaf child has the right to learn how to speak and to maximize the use of their residual hearing. The association remains committed to these ideals, and is working to encourage early identification of hearing loss at hospitals throughout the Nation.

An important part of this effort is the Hearing Alert Program. This program, sponsored by the association, uses brochures, films, video tapes, lectures, and an international parents organization to inform parents and physicians of the warning signs of deafness and the need for early intervention.

Speaking from experience, I cannot overstate the role that these early identification and intervention programs play in the education of deaf individuals.

My mother, during the first trimester of her pregnancy, contracted rubella. She was informed by our family physician that I was a "high risk" infant, and was told to be on the alert for symptoms of hearing impairment.

As a result of this advice, my mother noticed my hearing impairment immediately. When I was 4½ months old, my hearing impairment was diagnosed by an audiologist at a Philadelphia Children's Hospital, and I was referred by my family physician to the Helen Beebe Speech and Hearing Center in my home town of Easton, PA.

As an active member of the Alexander Graham Bell Association for the Deaf, Helen Beebe believed in the importance of the use of residual hearing. As a result, I was fitted with a hearing aid at the age of 7½ months and I immediately began auditory-verbal therapy which emphasized the use of residual hearing and speech.

Again, I cannot overstate the critical importance of early intervention and its use of amplification to develop the use of residual hearing. As a result of my auditory-verbal therapy, I was able to compete with my normal hearing peers. Mainstreamed from the beginning of my education, I have never requested special educational or support services.

In conclusion, I am here today because I believe that there are many other children who can benefit from early intervention and identification programs. I fully believe that these programs lay the foundation for better education for the deaf and open the door to a world of greater opportunity.

I am also here to credit the Alexander Graham Bell Association for the Deaf for its commitment to early identification and intervention. Without the dedicated work of the Association, many parents and physicians will remain unaware of the importance of early identification and intervention. Yet more importantly, many children would be denied the opportunity to fully contribute to society.

I would be pleased to answer any questions. Thank you.

[The prepared statement of David Davis follows:]

Statement of Mr. David Davis
Before the Subcommittee on Select Education
July 29, 1986

Mr. Chairman, on behalf of the Alexander Graham Bell Association for the Deaf, I would like to open by thanking you for the opportunity to speak before your subcommittee regarding the importance of early identification and intervention programs. Your willingness to address this issue is greatly appreciated.

My name is David Davis. I am twenty-one years old and will be a senior at Harvard University next year. I am currently a summer intern at the Alexander Graham Bell Association for the Deaf and have first hand experience with the importance of early identification and intervention programs. For you see, I have a profound hearing loss.

I am here, on behalf of the Alexander Graham Bell Association, to discuss the need to inform parents, educators, and physicians of the importance of early identification and intervention programs. Our experience with our own Hearing Alert Program has taught us that these programs provide the foundation for successful mainstreaming of deaf individuals.

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Speaking from experience, I cannot overstate the role that these early identification and intervention programs play in the education of deaf children.

My mother, during the first trimester of her pregnancy, was exposed to rubella. She was informed by our family physician that I was a "high-risk" infant and was told to be on the alert for symptoms of hearing impairment.

As a result of this advice, my mother noticed my hearing loss immediately. When I was 4 1/2 months old, my hearing impairment was diagnosed by an audiologist at a Philadelphia children's hospital and I was referred by my family physician to the Helen Beebe Speech and Hearing Center in my home town.

As an active member of the Alexander Graham Bell Association for the Deaf, Helen Beebe believed in the importance of the use of residual hearing. As a result, I was fitted with a hearing aid at 7 1/2 months and immediately began auditory-verbal therapy which emphasized the use of residual hearing and speech.

I cannot over emphasize the critical importance of using amplification to develop the use of residual hearing. As a result of auditory-verbal therapy, I was able to compete with my normal hearing peers. Mainstreamed from the beginning of my education, I have never requested special educational or support services.

In conclusion, I am here today because I believe that there are many other children who can benefit from early intervention and identification programs. I fully believe that these programs lay the foundation for better education for the deaf and open the door to a world of greater opportunity.

I am also here to credit the Alexander Graham Bell Association for the Deaf for its commitment to early identification and intervention. Without the dedicated work of the Association, many parents and physicians will remain unaware of the importance of early identification and intervention. Yet more importantly, many children will be denied the opportunity to fully contribute to society.

Alexander Graham Bell
Association for the Deaf
3417 Volta Place, N.W., Washington, D.C. 20007-2778 Tel: (202) 337-5220 Voice or TTY

OBJECTIVES

The Alexander Graham Bell Association for the Deaf is a nonprofit, membership organization which exists to:

- Promote the teaching of speech and language through maximal use of residual hearing
- Promote better public understanding of hearing loss in children and adults
- Promote early detection of hearing loss, particularly in infants, and prompt and continued use of appropriate hearing aids
- Inform, encourage and help oral deaf adults and parents of hearing-impaired children
- Collaborate in research relating to auditory/verbal communication
- Work for better educational opportunities for hearing-impaired children
- Provide in-service training for teachers of hearing-impaired children
- Provide scholarships for hearing-impaired students attending regular universities and colleges
- Gather and disseminate information on hearing impairment, causes and remedial treatment
- Collaborate with doctors, audiologists, speech/language specialists, and educators to promote educational, vocational and social opportunities for hearing-impaired persons of all ages

HISTORY

Founded in 1890 by Alexander Graham Bell, the organization now has members in thirty-eight countries. The Volta Bureau, initially built in 1893 to house the archival collection of volumes on deafness, serves as the headquarters of the Association. Located in Washington, D.C. it is now a national historic landmark.

FUNDING

Approximately 5% of the income is provided by the interest from the trust funds set up by Professor Bell. The three major sources of revenue are: membership dues; contributions from corporations, foundations and individuals; the sale of the Association's publications on all aspects of deafness.

ADMINISTRATION

The Board consists of eighteen voting members, including representatives from the three Sections that are an integral part of the Association; the International Parents' Organization (IPO), the Oral Deaf Adults Section (ODAS) and the International Organization for the Education of the Hearing Impaired (IOEHI).

PROGRAMS AND SERVICES

The Association's programs and services touch every facet of hearing impairment. Current activities include:

Hearing Alert! - A public education program to encourage early identification of hearing loss, particularly in infants, and to promote the need for prompt remedial action. Through brochures, films, video tapes, and knowledgeable speakers, the Association informs parents, medical practitioners, and civic organizations of the warning signals that indicate deafness and advises them on the steps that should be taken.

Children's Rights - Focussing primarily on the 1 - 16 group, qualified member volunteers throughout the United States and Canada work with the director of the program to ensure that hearing-impaired children and adolescents get the support, encouragement, and educational opportunities they need. Within the United States, parents are advised on all aspects of The Education of All Handicapped Children Act (PL. 94-142) and, if necessary, provided with assistance by educational specialists in due process procedures.

Individual Counseling - Professional staff members and volunteers provide guidance when requested.

Scholarships - Specifically funded scholarships are awarded to pre-lingually deaf students with profound hearing loss who are attending, or plan to attend, regular universities and colleges and who use speech to communicate.

Financial Aid Awards - Given to pre-lingually deaf students with profound hearing loss under the age of 19 years who are enrolled in independent or parochial schools for students with normal hearing.

Information - More than 20,000 inquiries are received each year from all over the world by mail, telephone and teletypewriter on every conceivable aspect concerning deafness. Questions are answered about tinnitus, cochlear implants, teacher training programs, oral interpreting services, lipreading courses, television captioning, and signalling devices for the home to name just a few.

Publications - Textbooks published under the Alexander Graham Bell Association imprint can be found in universities and colleges wherever teacher training programs exist; in schools, and in private homes. The authors are leaders in the field of auditory/oral education of deaf children. Parents have a choice of literature written specifically for them, and adults with hearing problems can find material on hearing aids, lipreading and auditory training. Video tapes and 16mm films are also available on loan or for sale. Members regularly receive the Association's professional journal, THE VOLTA REVIEW, the topical newsletter, NEWSOUNDS, and OUR KIDS MAGAZINE.

Regional Educational Conferences and Workshops - These are held in various locations throughout the United States and Canada several times a year for parents, deaf adults and educators. Attendance at the programs provided by the Association permits professionals to earn Continuing Education Units.

Biennial International Conference - Lasting five days, this conference provides 150 presentations on topics of interest to professionals, deaf adults and adolescents as well as parents. Membership meetings are held during the conference to allow frank discussion with the Board on matters of concern to individuals.

Research Library - The Volta Bureau Library contains one of the world's largest historical collections of publications, documents and information on deafness. In addition to the main collection which includes books, periodicals and indexed clipping files since the turn of the century, the library also houses a significant archival collection dealing with the history of education of the deaf dating from the 16th century. The oldest book in this collection is entitled, "Thesaurus Artificiosae Memoriae", dated 1579, which illustrates a system of fingerspelling.
The Library also contains many early photographs, personal correspondence of Alexander Graham Bell, Helen Keller, and Annie Sullivan, as well as a collection of antique hearing aids.

Mr. **Williams**. Thank you, Mr. Bartlett.

Mr. **Bartlett**. Thank you, Mr. Chairman.

Ms. Kinkor, let me ask specifically in the case of epilepsy but also with the other panelists for other conditions: Relate for us, if you will, those services that are provided, particularly in 0 to 2 but birth to 5, in which private health insurers cover the costs of those services.

For example, in the case of epilepsy some of the services that you described—do or did private health insurers help to pay for those costs? What conditions would you anticipate private health insurers would make if we had additional early intervention for some of those costs? Would private health insurers help to pay for those costs in the event this bill or something like it would pass?

Ms. **Kinkor**. Mr. Bartlett, thank you for asking me that question. I cannot relate to you general knowledge about what health insurers provide overall for children with epilepsy. I can only answer that question from a personal point of view.

In the case of my son Kevin and in the case of Patrick, who, remember, has epilepsy only 2 years, the health insurance coverage that we have, First Kaiser Permanente which is an HMO insurance, did not begin to cover the need for educational or psychological services. It was just not available to us, and when some did become available to us it was long after Kevin had first experienced epilepsy.

Second, the private insurance carrier that we have at this time, Connecticut General, does not cover the neuro-psychological services that my son needs without institutionalizing him first in a psychiatric hospital for 4 weeks. Can you imagine what that would do to Kevin? He's aged 10.

Again, I cannot provide you with general information as to what insurance companies do or do not cover in the range of psychological or educational services for kids with epilepsy.

Mr. **Bartlett**. Do any of the other witnesses have a comment on how this bill would relate to private health insurers? I think we want to be certain that we don't do something that would cause a reduction in the total funds that are available, if indeed those funds are available now. There's far more money in private health insurers than there is in the totality of the Education of the Handicapped Act.

Mr. **Meisels**. I'd like to recommend that you be in touch with the Department of Public Health in the Commonwealth of Massachusetts, because Massachusetts since 1983 has been successful in accessing funds in private sector as well as from Medicaid sources for early intervention services though it, of course, does not cover all of the costs and, particularly, does not cover the cost of the more historically educational kinds of therapy. I think it would be worth your while, because it has been done.

Ms. **Vincent**. Mr. Bartlett, I'd also recommend you look at your own State, Texas, which has done a very wonderful job of doing interagency coordination and has some experience now at looking at the issues related to private health insurance and ways to work with them as well as to use this kind of money as dollar of last resort.

Mr. **Bartlett**. Would it be your recommendation that we attempt to construct this legislation and other legislation so that the Federal dollars are the dollar of last resort, so we don't drive away other funds?

Ms. **Vincent**. Certainly, the recommendation of DEC, TASH and Interact that we must maintain the current funding that exists in early intervention. We cannot afford EHA to take on the kinds of funds that are now being used by other agencies.

Ms. **Kinkor**. Mr. Bartlett, I'm sure that our agency would be more than glad to provide any additional information regarding this question to you in writing.

Mr. **Bartlett**. We would very much appreciate that, if you can provide it within the next 2 weeks. With the consent of the chairman, we can make it a part of the hearing record.

Thank you, Mr. Chairman. I'll yield back the balance of my time.

Mr. **Williams**. Mr. Hayes.

Mr. **Hayes**. Just one question of Dr. Meisels. You say you're here to testify in favor of S. 2294 and to encourage you to amend or rewrite this bill so that it can more effectively achieve its objective.

Would you just briefly elaborate—Actually, you're not in love with 2294. Is that right?

Mr. **Meisels**. I'm in love with the idea of helping kids. I think we all are, but I think that it would be——

Mr. **Hayes**. You don't think 2294 is——

Mr. **Meisels**. No, I'm worried about it. I'm worried about 2294 going out of this committee and becoming law just as it is; because I'm worried that the States will say no, and they're going to fight it.

When I met earlier this month in Chicago with directors of State planning grants from the Midwest, many of them said that their States were very concerned about the bill, because of the fiscal considerations principally. They felt that the mandate would be an incentive and a very welcome one, but that the fiscal side of it, unless it were better planned than it is now, could result in States turning back from it.

I think that it has some real problems.

Mr. **Hayes**. Thank you. I yield back the balance of my time.

Mr. **Williams**. All right. I have no questions. Your testimony was particularly complete from each of you, and we very much appreciate your being here and sharing your time and expertise with this committee, very much.

The committee will give future and continuing consideration to this legislation. With the concurrence of my colleague, Mr. Bartlett, the committee will not be moving on the legislation prior to the August break. We will at that time continue to receive information, try to correct the wording of S. 2294 in a way that's compatible with the recommendations that have come before this committee during the past 3 days of hearings, and then when we return from the August break this subcommittee at that point will make a decision as to future movement of the legislation.

The Department of Education, as I mentioned earlier, had asked that the committee hearing be left open for their testimony; and we will do that. In the meantime, Mr. Bartlett and myself will be concurring with the Department concerning their views about this legislation.

Again, we appreciate the testimony of this panel and the other panels that have been kind enough to give us of their time and expertise.

The hearing is adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Additional testimony submitted for the record follows:]

REMARKS OF CONGRESSMAN DANIEL K. AKAKA
BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION
REGARDING THE BILL, S. 2294, THE EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986

THURSDAY, JULY 31, 1986

Mr. Chairman, as this body's only representative from the State of Hawaii, and as this body's only native Hawaiian, I would like to extend my sincere appreciation to you for your sensitivity to the needs of our nation's handicapped children. Indeed, your concern is strongly evidenced by the extensive hearings held on the bill, S. 2294, the Education of the Handicapped Amendments of 1986.

Today, with your indulgence, I would like to join the list of witnesses who have come forward to present their comments and concerns on this most noteworthy measure.

Mr. Chairman, as you are well aware, included in S. 2294 are a number of measures which are of urgent importance to native Hawaiians. Section 9 of the bill, for example, provides that the Secretary shall make available a grant within the State of Hawaii to address the needs of native Hawaiian children with handicaps. Likewise, Section 13, relating to Parental Training, provides that two grants shall be made to nonprofit organizations serving the needs of native Americans, including native Hawaiians. Other provisions of the bill similarly address the need for services for handicapped native Hawaiians.

I support these provisions for five very simple reasons. I support them because I believe that they are fair, reasonable, justified, needed, and most of all, long-overdue.

To understand the needs of native Hawaiians, one must first recognize that there is a fundamental difference between Western and native Hawaiian health concepts. For more than 2,000 years, native Hawaiians have had a distinct and continuous culture. Inherent in that culture is the evolution and development of a highly-refined, holistic health system integrated with the religious and life concepts of daily living. Good health, for example, has long been viewed as something which emanated from good and proper relationships between oneself and one's total environment. As pointed out in the report of the Native Hawaiian's Study Commission, "wellness was maintaining mana, quantifiable energy, which was both inherited and acquired. Proper balance of mana was promoted by harmony with oneself, with others, and with the gods and nature, through continuous communication with the spiritual realm and correct thought and action."

This attitude clearly differs from that of the Western society which approaches health as a separate entity distinguishable from other social concepts. Particularly notable is the belief, in general, that health promotion, disease prevention, and health protection are the responsibilities of the family, both in their causes and their cures.

This belief, in fact, is as much the strength as it is the weakness of native Hawaiian culture. For, while the native Hawaiian culture continues to survive, the environmental elements to which they had long been accustomed have not. Western contact has largely influenced a process of deterioration of Hawaiian health patterns. There exists no longer a harmonious environment. Native Hawaiians, in a health context, are effectively anachronisms.

A recently-reported study on the health care needs of native Hawaiians [ordered under the FY 1984 Supplemental Appropriations Act] reveals a very dismal, yet painfully true, picture of this group. For example, native Hawaiians:

-- have higher proportions of social problems, including assaultive acts and antisocial behavior; alcohol and narcotics use; school performance impairment; suicide among young adults and elderly males; child abuse and neglect; residence in correctional institutions; academic failure and poor school performance; and stress;

-- underutilize mental health services because they are culturally unacceptable;

-- have a lower life expectancy due to higher accidental death rates and greater risk of serious illness; higher infant mortality rates; suffer disproportionately from chronic diseases such as diabetes, heart disease, hypertension, and cancer;

-- have higher cancer rates for cancers of the stomach, lung, and female breast and cervix; have a poorer survival rate from cancer compared with others diagnosed with the same disease; experience heart disease and hypertension at earlier ages; have higher rates of teen pregnancy and illegitimate births; rank highest in having late or no prenatal care, in smoking and alcohol consumption during pregnancy, in toxemia and urinary tract infections during pregnancy and in complications of pregnancy among the over-35 age group;

-- receive fewer health services and participate less in health education, health promotion, and screening and referral programs;

-- tend to enter medical treatment at the late stages of disease, primarily because of lack of accessible resources, financial barriers, and lack of acceptability of services due to cultural barriers.

I bring these facts to the attention of the Committee to demonstrate the dire health status of native Hawaiians, a people who find themselves at the lowest socio-economic level in the State. Indeed, these results are but a glimpse of the problem. Further study of the native Hawaiian health situation will surely reveal even greater disparities between this group and their non-Hawaiian counterparts.

Through its training, research, and development provisions, S. 2294 can provide significant relief for native Hawaiians, the extent of which we may not even able to comprehend. I call upon the wisdom of the Committee to recognize the value of this investment in the native Hawaiian population, and urge your support for the Senate-passed provisions.

NAESP

National Association of
Elementary School Principals

July 10, 1986

The Honorable Pat Williams
Chairman
House Select Committee on Education
2457 Rayburn House Office Building
Washgington, D.C. 20515

Dear Mr. Williams:

The National Association of Elementary School Principals would greatly appreciate your consideration of the following changes in S 2294, sponsored by Senator Lowell Weicker, which has now passed the Senate and has been sent to your committee.

1. S 2294 calls for the same due process provisions as appear in PL 94-142. The application of these specific procedures to the birth-two population and its health and social service needs may not be appropriate or practicable. Health agencies may not be as equipped to use these procedures as are education agencies. There may well be a need to review with representatives of these agencies the best means of assuring responsible and responsive due process procedures for parents and their very young handicapped children.

2. S 2294 calls for a transition process at the time the child becomes age three. We would like to see some language inserted that would maintain the interagency continuation of health and social services while the health program is blended with the needed education provisions to create the individualized education programs. At the transition time, the health agencies should not just bail out and leave all services as the responsibility of the education agency. It is important that the health agencies continue to provide that continuum of health services begun during the birth-two years period.

Thank you for considering our comments as you begin consideration of this measure. We would be happy to provide further comment on this issue should it become appropriate.

Sincerely yours,

Ed Keller

Edward P. Keller
Deputy Executive Director

EPK/mh

1615 Duke Street, Alexandria, Virginia 22314-3483 (703) 684-3345

STATEMENT OF MADELEINE C. WILL

ASSISTANT SECRETARY FOR SPECIAL EDUCATION

AND REHABILITATIVE SERVICES

U.S. DEPARTMENT OF EDUCATION

ON

REAUTHORIZATION OF DISCRETIONARY GRANTS

EDUCATION OF HANDICAPPED ACT

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION,

U.S. HOUSE OF REPRESENTATIVES

TO BE SUBMITTED FOR THE RECORD

JULY 29, 1986

Mr. Chairman, and Members of the Subcommittee,

Thank you for this opportunity to present written testimony on the reauthorization of programs under the Education of the Handicapped Act (EHA). The Department of Education continues to endorse a one-year automatic extension, under the General Education Provision Act (GEPA), for the EHA programs that are scheduled to expire at the end of this fiscal year.

Our recommendations for these programs are being finalized for submission to Congress with the fiscal year 1988 budget. However, there are several issues of particular interest to the Department of Education regarding early intervention services and early childhood education that are appropriately examined at this time. Our comments are prompted by the Subcommittee on Select Education's consideration of S. 2294, as recently passed by the Senate. That bill would create a new Federal program serving children birth through two years of age, and mandate services for all children 3 through 5 regardless of State law or practice.

Support for Principles of Early Intervention

The Department of Education has actively supported efforts to stimulate services to preschool handicapped children. Since 1968, with the passage of the Handicapped Children's Early Education Assistance Act (P.L. 90-538), the Department has, through the Handicapped Children's Early Education Program (HCEEP), undertaken a variety of demonstration, outreach, research, State planning, and technical assistance programs designed to improve the effectiveness of early intervention and to stimulate the adoption of innovative practices in the early education of handicapped children.

The Department has supported and will continue to support projects that develop and test the proposition that intervention services for handicapped children during the early years lessen the subsequent need for special services; increase their independence; facilitate positive and measurable changes in a child's academic, social, physical, and emotional development; are beneficial to the child's family; and improve community attitudes toward the handicapped.

Early Intervention Services for Ages Birth through Two

For several years, our efforts to promote early intervention services were concentrated on discrete, small-scale demonstration projects rather than statewide service systems. More recent Department efforts to stimulate statewide early education planning have, unfortunately, provided us with little reliable information on the current status of early intervention services. As a result, meaningful data on the varying services provided by States is not yet available. In addition, we have only a rudimentary picture of the population of handicapped children birth through two who need services, the types of services needed, and the most appropriate service delivery mechanisms. Many questions remain unanswered such as:

- the extent to which services should be provided to "at risk" and "developmentally delayed" children as distinguished from those with identifiable handicapping conditions;
- who should provide services, educational agencies or health agencies; and,
- what role insurance providers should play in the delivery of services.

We do not know enough about these and other issues to structure a Federal program or define the appropriate role for the Department of Education in serving this population. For this reason, we are unable to support the new State grant program for handicapped infants proposed in S. 2294.

To answer these and other questions, the Department proposes to carry out a comprehensive study of services for handicapped infants. Such a study could be conducted with existing resources under discretionary authority currently in the EHA, and would therefore require neither new substantive authority nor additional appropriations. The study might be jointly undertaken with the Bureau of Health Care Delivery and Assistance, Division of Maternal and Child Welfare, Department of Health and Human Services. The study would describe the interactions among various components of the overall service systems, identify service needs, explore gaps in services, and identify potential service populations.

The Department also proposes to improve intervention services through statewide model projects which would foster statewide systems changes. These models would emphasize coordinated interagency strategies for improving the quality, comprehensiveness, and accessibility of service. This initiative can also be undertaken with existing resources under current program authority.

Early Childhood Education for Ages 3 through 5

The Department continues to support efforts to stimulate increased services to handicapped children aged 3-5. Currently, nineteen States mandate services for all 3-5 year olds, while twenty-three States mandate services for some portion of the 3-5 year old population. Child counts for handicapped children aged 3-5 have not increased substantially in recent years. However, the increase in the 1984-85 child count is the largest increase in five years.

The Department believes that services to preschool handicapped children can be further expanded through a revision to the Preschool Incentive Grants program legislation, rather than through the imposition of a nationwide mandate, as provided in the Senate bill. We recommend that Preschool Incentive Grants funds be allocated on the basis of each State's annual increase in the number of children 3-5 served by the State. Currently, funds are distributed based on the total number of children served with most of the funds used to support services to children for whom States already mandate services. The number of handicapped children aged 3-5 served by the States has remained approximately the same as a percentage of population over the last several years. Therefore, it is unlikely that this program currently provides a significant incentive to serving additional children. Distributing funds based on increases in numbers of children served would provide an increased incentive to expand services.

Other Concerns with Early Childhood Education

The Department is concerned with other provisions of S. 2294 relating to early education. The consequences of adding "developmentally delayed" to the definition of handicapped children aged 3-5 and handicapped infants aged birth to 2 are likely to be substantial in terms of the number of additional children to be served and the adverse effect on services to children who are now served by the program under the current definition of handicapped children. We question whether the services needed by these additional children are the kind of special services contemplated by the current program. The bill's approach is also inconsistent with the current statutory approach of defining handicapped children as those with a specific, identifiable handicapping condition. We recommend that the statute not be changed in this manner.

Summary

The Department recommends that a study be conducted before any Federal legislation is enacted providing for Statewide service systems for handicapped infants. Also, the Department proposes to support models of Statewide systems for early intervention service delivery systems.

The Department opposes mandating provision of services to handicapped children ages 3 through 5. The Department believes that an amended Incentive Grant Program, with funds based upon annual increases in the child count, will provide a sufficient incentive for the expansion of services to preschool handicapped children.

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**An Independent
Federal Agency**

STATEMENT OF: MRS. SANDRA S. PARRINO, CHAIRPERSON
NATIONAL COUNCIL ON THE HANDICAPPED

SUBMITTED TO THE: HOUSE SUBCOMMITTEE ON SELECT EDUCATION

REFERENCE: S.2294, THE "EDUCATION OF THE HANDICAPPED ACT
AMENDMENTS OF 1986"

DATE: AUGUST 12, 1986

The National Council on the Handicapped is pleased to submit written testimony to the House Subcommittee on Select Education regarding S. 2294, the "Education of the Handicapped Amendments of 1986." As you are aware, the bill will lower the mandate of P. L. 94-142 the "Education for All Handicapped Children Act" to serve children ages 3 to 5 and would create a new program which would serve children from birth through age two.

The Council is interested in a wide variety of topics concerning the education of disabled children which include: implementation of the least restrictive environment; impartiality of the due process procedure; and transition of disabled youngsters from school to employment and independent living. These and other topics were discussed in our recently released report, Toward Independence, which you have received. While our written remarks will focus primarily on the early childhood education programs outlined in S. 2294, we would like to discuss these issues with the subcommittee in the near future.

The Council is encouraged by the possibilities which this proposed legislation offers to improve the lives of very young disabled children and their families. These proposed improvements are consistent with the Council's recommendations in its recent report, Toward Independence, including lowering the mandate of P. L. 94-142 to serve every disabled child from birth.

The Council has discussed many of the concepts which are raised in S. 2294 and would like to share some of these ideas with the subcommittee. While we are enthusiastic about the possibilities offered in S. 2294, we have a number of concerns: 1) coverage of children who are "at risk"; 2) parental involvement in meeting the educational and developmental needs of very young disabled children; and 3) financial matters which must be addressed if these young children are to be served appropriately.

S. 2294 defines those children who are to be served by this legislation as those youngsters "who are substantially developmentally delayed or children with specific congenital conditions who by reason thereof require early intervention services." While this definition will certainly serve many children who are not currently receiving early intervention services, the Council is concerned that the Senate definition does not include those children who are "at risk" of developing a disabling condition.

Children with disabilities, especially very young children, often defy diagnosis and classification. Further, many young children may be "at risk" due to low birth weight, prematurity, or may be children who are born to parents who are themselves developmentally disabled and thus may require special attention. Many of these youngsters would not be "substantially developmentally delayed" under the Senate's definition but will clearly be "at risk" of developing a disability during their formative years.

The National Council on the Handicapped is aware of the fiscal crisis facing our Nation and the difficulties the Congress may encounter as it seeks to pass new legislation. But we are equally aware of the cost-benefit (both in fiscal and human terms) of serving disabled youngsters and those who may be at risk of becoming disabled.

Two sections of Toward Independence recommend the need to serve those youngsters who are "at risk". The Appendix to our report cites a study done by the House Select Committee on Children, Youth and Families, which provides conclusive data to support early intervention services. The report states: [if] "intervention for handicapped infants is delayed until age 6, special education costs to age 18 are estimated at $53,350. Intervention at birth is estimated to result in special education costs of $37,272, a savings of $16,078." The report further states that for every $1.00 invested in high quality preschool programming, there is a $3.00 reduction in public special education costs. We believe that these are compelling figures which underscore the importance of early intervention services for young disabled children, including those youngsters who are perceived to be "at risk."

The Council is aware that the subcommittee has received legislative language from several groups which is designed to address the problem of serving those children who are "at risk." Clearly, all of these suggestions merit careful consideration. As the subcommittee deliberates on this matter, the Council is willing to provide assistance in the analysis of how this legislation will affect the overall population to be served.

The Council firmly believes that parents of disabled children must be actively involved in their child's education. Parent involvement is even more important for the very young disabled child whose parents are the primary source of love, care, and education. Parents must learn to understand their child's unique needs and how they can become partners in their child's early intervention program. An equally important aspect of early intervention programs must be opportunities for support to parents which will help them cope with having a young disabled child.

S. 2294 creates Early Intervention Councils which are charged with designing and implementing a state early intervention program to serve disabled children from birth through two years of age. We feel strongly that the Early Intervuntion Councils must have adequate parent representation in order to adequately meet the needs of very young children and their families. We agree with the recommendation made by several other witnesses that parents should comprise 25%, or at least two Council seats whichever comes first.

Another important aspect of parental involvement relates to the provision of due process procedures. In the implementation of P. L. 94-142, due process has been critical to assuring that disabled children, in fact, receive a free and appropriate public education in the least restrictive environment. We are pleased that the same due process procedures have been extended to cover very young children.

During the recent hearings before the subcommittee, much was said concerning the fiscal impact of S. 2294. While current cost estimates of the proposed legislation vary significantly, one thing is certain, the monies within the Education for the Handicapped Act cannot be expected to pay for the entire early childhood education program for disabled youngsters. One proposed purpose of the Early Intervention Councils is to identify other funding sources within each state which are currently providing services to children from birth through age two. It is imperative that Federal, state and local health, education and social service programs plus private sector initiatives be appropriately coordinated so that all youngsters are able to receive comprehensive services.

In Toward Independence the Council suggested that monies which are currently serving young children, such as the Medicaid programs and the so-called 89-313 program found within Chapter I of the "Education Consolidation and Improvement Act" be coordinated. Other examples of Federal programs serving youngsters with disabilities which should be coordinated include: Head Start Program, Maternal and Child Health Program, EPSDT, and Child Welfare Services. Coordination of these programs with the programs authorized by the "Education of the Handicapped Act" will assure effective service delivery to this population of vulnerable children. Such coordination of services, coupled with a strong due process procedure will help assure that these young children and their families are effectively served.

During the hearings several witnesses suggested that monies within EHA become the "dollar of last resort," i.e., that other funding sources which currently provide these services continue to maintain them. This is consistent with the Council's recommendation that an appropriate funding mechanism be developed. In light of the current fiscal crises facing our Nation, it would seem that such a provision would maximize the use of scarce dollars for the benefit of young disabled children. However, such a provision must not be used to abdicate any one agency's responsibility, rather to maximize services on behalf of the disabled child and his or her family.

Thank you for the opportunity to express our views on the early education of disabled children. It is our understanding that the Council will be invited to testify when the Subcommittee on Select Education convenes hearings on its proposed legislation. We look forward to this opportunity and we are hopeful that these hearings will occur early in the Fall so that this legislation can be enacted prior to the adjournment of the 99th Congress.

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Statement of

The National PTA

Regarding

The Act to reauthorize certain programs under the Education of the Handicapped Act, to authorize an early intervention program for handicapped youth, and for other purposes.

S. 2294

Before the

Select Education Subcommittee

U.S. House of Representatives

Washington, D.C.

July 25, 1986

By

Millie Waterman, Vice-President for
Legislative Activity, The National PTA

Mr. Chairman, The National PTA, comprising over 5.8 million members in over 25,000 local units throughout the country and Europe, appreciates this opportunity to submit our views on S. 2294, the Handicapped Amendments of 1986. The National PTA is the largest child advocacy organization in the nation, and has a deep commitment to the health, protection, welfare and education of our young. The National PTA is grounded in a fundamental belief that parents need to be involved in the education of their children, and that parents participate as equal partners at all levels of government to assure that all children receive excellence and equity in the public education setting. It is for these reasons that the National PTA has a major stake in the public policy discussions related to S. 2294.

The National PTA has a long history of support for federal as well as state and local commitment to the education of special population of children, especially those children who have been traditionally underrepresented and underserved. The National PTA Legislative Directive related to Children With Special Needs states that "The National PTA work to ensure that the federal government maintain an educational and funding commitment to children with special needs, including but not limited to, Chapter 1, gifted and talented, handicapped and vocational education."

P.L. 94-142 represents an educational milestone in our country. Of all of the thousands of pages published on educational reform in the past several years, none focuses on the basic assumptions and premises as does P.L. 94-142. A model of educational improvement, P.L. 94-142 set the goals of excellence and equity long before the present reform movement. Notwithstanding some of the problems that exist in some districts, it is not the sound and the fury of implementation that captivates our attention, but the attempt to fine-tuning one of the most successful federal educational laws. The bottom line is that thousands of children who otherwise would have been ignored in many states are now receiving educational services that allow them to contribute to society in meaningful ways.

Under present law, the requirement to provide special education does not include all handicapped children, however. The requirement in P.L. 94-142 to provide special education does not apply to children aged three through five and eighteen through twenty-one, "if the rule would be inconsistent with state law or practice." Early education is left to the states at the present time. If the states choose to serve children aged three through five and eighteen through twenty-one, the federal government will pay a portion of their costs. S. 2294 would amend the Education for all Handicapped Act by requiring that children age three through five be provided special education services. The issue under discussion, then, is not to create a new federal policy related to the education of handicapped children, but whether there is a federal will, commitment and appropriations that will extend services to the three through five year old age group. The second issue is how to close the gap between policy and implementation; between mandate and quality programs. It's one thing to define the problem; its quite another to find the correct match of services for these children. Both of these issues must be considered by this Committee as it deliberates the provision of the bill.

The National PTA supports the concept of extending educational services to handicapped children. The need cannot be denied. Research findings are replete with proof that preschool education works. There is little disagreement that it can reduce the effects of a handicap, resulting in higher scholastic achievement and cutting the need for special education in future years. All the remediation that occurs later in a handicapped child's life is limited by the lack of early intervention. Early childhood and intervention programs also are an economic investment, as well as a humanistic investment. A child treated early can save society, on later, more expensive special education services costs. From an educational, child development and economic standpoint, the importance of early intervention to the child, to the family and therefore to society is clear.

The latest Education Department data shows 19 states mandate services to all handicapped children aged three through five and 23 other states require services for certain preschool children, based on age and handicap. The states that have taken the lead for providing extended services should be commended, but over half of the states provide little or nothing at all. This is an erratic distribution of services, creates funding and educational opportunity inequities from state to state, and needs to be corrected. While on one hand, it is preferable to encourage voluntary compliance, on the other hand, some states do little at all without a federal mandate. The National PTA believes that special education for handicapped children is of such importance to the achievement of nationwide goals that the federal budget must reflect a share of the total investment necessary for implementation.

S. 2294 does present questions that this Committee and those supportive of preschool for handicapped children must address. S. 2294 is the focal vehicle, the bill that will drive the next round of policy discussions that will mandate services to a new age group of handicapped children. Much has been learned from ten years of experience and implementation of P.L. 94-142 related to political and community support of the program, funding, implementation, leadership, and quality services. There will be emotional cries from those who don't believe that the public schools have any business in the education of handicapped age 3-5 to those who will insinuate that non-support of the bill in its present form translates into non-support of education for handicapped children. It is the difficult task of this Committee to refine the broad policy sweep that S. 2294 has initiated. If the goals of S. 2294 are to be fulfilled, consideration of a systematic plan--policy into practice based on a review of what work--needs to be employed. In the interest of wanting this new initiative to succeed, the National PTA has the following questions that were not adequately answered during the Senate deliberations:

FUNDING:

What are the total estimated costs to implement S. 2294 at all levels of government, especially the additional mandated services for 3-5 year olds? The federal government has not assumed its promise to fund up to 40% of the costs for educating 5-17 year olds, what are the chances of the federal government delivering on a new program? If resources are not adequate to fund S. 2294, will it create a financial drain from present services being delivered by the current program? In order to gain political support, is it feasible to make the 3-5 portion of S. 2294 an entitlement program?

IMPLEMENTATION AND QUALITY SERVICES

Has attention been paid to appropriate systematic implementation of the program that will ultimately lead from compliance to quality programming? For instance, are there adequately trained teachers to meet the demand for the additional services and for this new age group? Are there sufficient numbers of adequately trained teachers to fill the need created by the expanded services? Do schools have the appropriate space, facilities and capital outlay? Have there been provisions to coordinate curriculum throughout the education for the handicapped instructional program, birth through 21? Who should be providing services beyond the educational services? Have efforts been discussed to include social workers, psychologists, therapists, and medical doctors and having these agencies pay for part of the costs? What would the role of these professionals be? As modern medicine has drastically improved the number of premature babies to survive, what would be the impact on public schools if schools waited until the child is five years old to provide services? Have colleges and universities developed quality training programs to meet the professional service needs of the handicapped child? Have there been provisions to train teachers? Work with colleges and universities to design additional courses to address the special unique differences related to the needs of the birth through five age group?

COMMUNITY AND PUBLIC SUPPORT

> Has consideration been given to garnering public support through community leadership? What is the role of the public schools in providing services for age 3-5? What roles do other agencies play? Has appropriate leadership been developed with sufficient resources in the regular school setting to provide for coordinated services for all children, special needs or not? Are the timelines in the bill to provide for preparation of implementation sufficient too lengthy? Should there be public hearings before plans and applications are submitted for the 0-2 program?

From past experiences, we know that there are many barriers to reform and change. Sound public policy and the need for systematic policy development requires that deliberate consideration be given to the areas enumerated above. Adequate funding, instructional development, professional development, administration and public support are all necessary for quality programs. It is in the interest of the success of S. 2294 and quality programming for children that these issues be given some attention. In this era of declining school budgets and increasing competition or funds, we need to have some precise answers to give to those who are skeptical that extending special education services would not be worthwhile.

The National PTA:

1. Supports the concept of S. 2294

2. Believes in a strong federal role in mandating services for handicapped children

3. Requires that the federal government actively support the mandates through adequate funding

4. Believes in parental involvement through I.E.P.s and the Council

5. Encourages program excellence through provisions that assure competent teachers; coordinated instructional programs and curriculum; teacher and administrator professional development and training programs; and committed administrator leadership.

Mr. Chairman, we thank you for this opportunity to present the concerns and the views of the National PTA.

TESTIMONY OF THE
INTERNATIONAL READING ASSOCIATION
before the subcommittee on
SELECT EDUCATION
U.S. HOUSE OF REPRESENTATIVES
JULY 29, 1986

The International Reading Association (IRA) is a professional education society of over 250,000 members and affiliate members. IRA is concerned with the direction and the impact of S. 2294, the Education of the Handicapped Amendments of 1986. These Amendments unfortunately build on many of the structural weaknesses of P.L. 94-142. Generally, these weaknesses lie in the lack of specific definitions in the statute and the 1986 Amendments, which has resulted in many children receiving inappropriate educational services. Building on P.L. 94-142 programs for pre-school children will expand the errors in the statute to a population in need of different assistance.

The Amendments have not been written with precise definitions of what services are to be provided, how those services will be identified, implemented, or evaluated. While the term "developmentally delayed" is a useful concept for outlining a non-labelling philosophy, it is at best a generic term. The TREATMENT OF DSM-III PSYCHIATRIC DISORDERS by William Reid lists eight definitions under the general heading "Pervasive Developmental Disorders." As a general description under this heading Dr. Reid writes: "... there is typically considerable distortion in many developmental areas. This makes definitive diagnosis and treatment difficult (page 29)." The IRA publication A DICTIONARY OF READING AND RELATED TERMS contains ten concepts with the lead word developmental. The 31st edition of BLACKS MEDICAL DICTIONARY contains no citations for the word developmental. In short, without specific definitions, each professional who brings experience and knowledge to assist the child will also bring different concepts to define "developmentally delayed."

The impact of a definition that is open to a wide range of interpretations will be equally broad: different professions will be using different terms, families seeking services will need more assistance in interpreting the statute and the recommendations of professionals, states will interpret the requirements differently, and the impact of the Amendments will be difficult to measure. This wide range of interpretations is especially significant because the Amendments require different agencies to be included to serve the best interest of the child.

Impreciseness of terms has been a catalyst for many of the problems inherent in P.L. 94-142. Problems with definitions have lead to misdiagnosis and inappropriate treatment of many children who have been labeled as being learning disabled. The terminology "learning disabled" has been and continues to be a term that is interpreted uniquely by professionals, institutions, and researchers with the result that the distinct professions remedied the problem differently. However, because of the Federal statute, the term has been defined to mean a process dysfunction to be remedied by a special class of professionals, the learning disabilities specialist. What is significant is that this process dysfunction may not be only a perceptual problem, but it may also be an organizational and/or a cognitive problem.

The point is that the Federal statute did not adequately define the major diagnostic category in the legislative language and many children are now being served with interventions that are not fully evaluated. While early identification and intervention for three to five year old children with cognitive, perceptual, and/or organizational problems can be critical to an effective remedial program, the definitions of P.L. 94-142 are inadequate for establishing program criteria.

The report that accompanies S 2294, Report 99-315 section on "Cost Estimate" (page 21) raises the question that "many disabilities, especially learning disabilities, may not (emphasis added) be identifiable at the younger age." While this discussion relates to the cost estimate of the program, it is a critical question of content as well. If the same definitions are to be used from P.L. 94-142, then many children will be identified as being learning disabled based on a wide variety of tests, observations, and notions of what learning disabilities in young children are -- without a precise definition of on which to base the diagnosis. This is not to say that children who manifest learning problems should not be eligible for services under this program, only that it is a mistake to take notions defined for older children and use them with younger children. For example, if a third grader is reversing letters, some believe that this is a sign of a process dysfunction, yet in a four year old this same behavior would be within the norm. While it could be argued that the case falls within the parameters of "developmentally delayed," the counter statement is that letter reversal is a behavior that is not always developmental and therefore the etiology of the similar problem in younger children is open to a wide range of interpretations. The critical point is that S.2294 and P.L. 94-142 should not be automatically married; S.2294 should be more specific in its design to educate young children.

Another weakness of S.2294 is the use of the Government Accounting Office (GAO) for the evaluation of the policy's effectiveness. S.2294 outlines no criteria for effectiveness. The Congress may wish to add some benchmarks other than numbers of children served. This could include, but not necessarily be limited to, how the educational programs within the states are improved. Specifically these points could be: how children are prepared to enter school, how the children in the program enhance their learning in terms of specific training and educational goals. This could be developed within the legislation to require that the individualized plans for the handicapped children state identifiable goals that could be monitored and evaluated by the state agencies and the GAO. However, the weakness of the evaluation program is directly related to the lack of specificity of the definitions and their relationship to the notions and procedures of P.L. 94-142.

Overall, the IRA believes that handicapped children need to be reached at younger ages. The language of S.2294 is imprecise and open to repeating many of the mistakes of P.L. 94-142. Mistakes are costly for the individuals and society.

Testimony before the

HOUSE SUBCOMMITTEE ON SELECT EDUCATION

on

The Education of the Handicapped Amendments of 1986

by

Scott D. Thomson
Executive Director

The National Association of Secondary School Principals
1904 Association Drive
Reston, Virginia 22091

August 1, 1986

Mr. Chairman, my name is Scott Thomson. I am Executive Director of the National Association of Secondary School Principals, and I want to thank the Committee for inviting us to submit testimony on the important measure before you, S. 2294. NASSP is the largest school administrator organization in the nation, representing 37,000 middle, junior and senior high principals and assistant principals, who in turn are responsible for the education of 17 million youth.

The bill before you expands the federal mandate under Part B of the Education of the Handicapped Act requiring schools to serve handicapped children aged 3 to 5 years of age. Additionally, this measure would authorize a new federal program of formula grants to states for the development and operation of early intervention services for handicapped infants from birth through age two. Although this bill is focused on preschool children, our membership is profoundly interested in it because of its potential impact on state and district-wide programs.

Mr. Chairman, members of this distinguished committee, let me address the central issue of S. 2294--the expansion of the federal mandate that all handicapped children begin receiving "educational" services at the age of three years. As a representative of our membership, I want to express my strong objection to the manner and speed with which this important issue has been moved through the legislative process to date. The U.S. Senate has acted on this important legislation, which profoundly changes current public policy, in an inadequate way forgoing any meaningful discussion in Committee or dabate on the Senate floor. In fact, direct contact with a number of Senators since passage of this legislation indicates that many members are completely unaware of its completion. The Senate has failed its great heritage of being the world's greatest deliberative body. We trust the U.S. House of Representatives will act more prudently.

We at NASSP are calling on this distinguished committee to engage in a thorough examination of the important impact of this legislation on the nation's schools. Due to the short of time remaining in this session, we believe the Committee should not report this legislation to the House floor prior to adjournment of the 99th Congress sine die. Instead, Mr. Chairman, we ask that you and your Committee take this important measure up next year in concert with the complete review and reauthorization of the Education of the Handicapped Act.

Let me delineate some of the substantive issues which concern us regarding the proposal. First, the issue of financing. The cost of implementing this additional mandate on schools is of great concern to us. As you know, P.L.94-142 has been dismally underfunded since its passage in 1975. States and local school districts have shouldered the vast majority of excess costs of education of handicapped children aged 5-17, in spite of the 40 percent authorization in the current law. We have long held the belief that federal mandates placed upon schools should and must be adequately financed with federal resources. With this primary issue yet unresolved, we believe it inappropriate for Congress to contemplate yet another mandate on what is already a significantly underfunded program. Essentially, we are saying that without a firm commitment to federally fund the program as it exists today, it is totally inappropriate for Congress to expand the mandate to serve 3 to 5 year olds.

Furthermore, the Committee should be fully aware that without commensurate increases in funding for this additional mandate more and more state and local funds will be diverted from regular school programs. These are tough choices that are already being forced on local and state decision makers. Meanwhile, Congress comfortably takes the high ground expressing its continued commitment to handicapped children while other levels of government face the fiscal realities of its implementation. We ask that the Committee carefully consider these grave concerns prior to further action on this measure. We understand that a number of states have already mandated services for 3 to 5 year old children, however, these states have also committed additional funds for this purpose. This should remain a state prerogative.

Aside from the fiscal concerns mentioned, we at NASSP believe that many if not most services that would be provided to 3 to 5 year old children would not be "educational" so much as developmental in nature, including providing physical therapy, psychological services, and perhaps other health services. We believe that these types of services would be best provided by other agencies, better suited to their provision. Instead, the many services provided to disadvantaged children through the Headstart program could be tailored to meet the needs of handicapped children aged 3 to 5. We strongly urge the committee to consider providing appropriate "Headstart services to handicapped children, rather than mandating these services through the Education of the Handicapped Act.

In spite of the fact that this proposal is a preschool measure, we at the secondary level believe that unless Congress responds to the funding crisis surrounding P.L. 94-142, secondary schools will experience yet another reduction in the resources available to them if this mandate is imposed upon school districts nation-wide.

Regarding the new formula grant program called for in S. 2294 which would provide, at no cost to parents, services to handicapped children birth through two years we recommend that a more in depth analysis of such a program be made by the Committee next year when reviewing all issues surrounding reauthorization of the Handicapped Act.

Mr. Chairman, it is a pleasure to present our views about this important matter. We look forward to working closely with you and your staff on this and other important issues pertaining the improvement of education to all the nation's youth.

Statement of the
American Rehabilitation Counseling Association

and the
American Mental Health Counselors Association

on
S. 2294
The Education of the Handicapped Amendments of 1986

before the
Subcommittee on Select Education
U.S. House of Representatives

July 29, 1986

Randall Parker, Ph.D
President
American Rehabilitation Counseling Association
Professor, Rehabilitation Counseling Education
University of Texas at Austin

Dave Brooks, Ph.D
President
American Mental Health Counselors Association
Assistant Professor, Counseling and Guidance
Syracuse University

ARCA and AMHCA are divisions of the
American Association for Counseling and Development

Statement of the American Rehabilitation Counseling Association and the American Mental Health Counselors Association on S. 2294 The Education of the Handicapped Amendments of 1986 before the Subcommittee on Select Education U.S. House of Representatives

Mr. Chairman and members of the committee, thank you for providing us with the opportunity to testify on S. 2294, the Education of the Handicapped Amendments of 1986.

I am Randall Parker, President of the American Rehabilitation Counseling Association, or ARCA, as well as serving as professor of Rehabilitation Counselor Education at the University of Texas at Austin. With me is Dr. David Brooks, President of the American Mental Health Counselors Association and assistant professor of Counseling at Syracuse University.

Like nearly all the other organizations who have testified before the subcommittee, we support the concepts behind S. 2294. The positive effects of early intervention have been clearly demonstrated in a broad range of research and reported in professional literature. And while early intervention in both the birth to two and three to five age groups seems a common sense approach, it is a strategy often neglected by the states due to a lack of funds or lack of expertise.

A federal initiative in this area is appropriate. The national government is able to offer a resource base of knowledge, expertise and funding unmatchable by any individual state. In stating this, we do not mean to imply that the federal government should be wholly responsible for funding these programs. Beyond a basic grant to ensure that all states offer some basic service, funding should be distributed on a state match basis. Requiring states to include local money in the program will facilitate inter-agency communication and hopefully help prevent duplication of services.

Increased intervention in the early age ranges will of course impact on other programs in EHA. As more students receive services at an early age, their needs during the school ages will change. Students will be better prepared to be "mainstreamed" into classrooms with their non-disabled peers. School age programs will need to incorporate skill training at more advanced levels than they have in the past. As the child progresses through education, the school system will have to assume greater responsibility for preparing students for higher education and the workforce.

In order to meet these needs, the full range of rehabilitation professionals must be recognized and included in this legislation, particularly under related services. For example, rehabilitation counseling has never been directly included in section 602 of related services. While it has generally been assumed by Congress and federal agencies that the services of rehabilitation counselors can be used under the act, some states have maintained a more restricted view of the guidelines. For this reason, we ask that the committee include rehabilitation counseling in the related services components of EHA.

Dr. Brooks:

Mr. Chairman, children with handicaps and their families often need a broad range of counseling services. A childs disability can often times greatly increase the stress on a family. The special needs of a child with a disability can take away from the attention normally given to other children in the family. The needs of the child can also interfere in the normal communication between spouses.

In the past, the school counselor has often helped mediate these needs along with other social service personnel in the school systems. It is vital that these needs also be addressed in early intervention. State mental health systems and community mental health centers should be integral parts of the service delivery system. These services can help families develop new communications skills and maintain family bonding. These family supports are vital in helping children with disabilities develop to their full potential both educationally and personally.

For your information, we are submitting several items for the committees records. These include some of our correspondence with the Senate committee, a statement from the American School Counselor Association on the role of the school counselor in EHA, and an article from the American Association for Counseling and Development Guidepost on the role of the counselor in EHA.

In closing, I would like to reaffirm several of our positions.

First, federal funding in early intervention should be "final tier" or "last resort" funding. The bulk of coverage should come through sources such as private insurers. However, it is vital that the federal government provide a safety net for those who do not have insurance coverage.

Secondly, funding beyond a base level should be matched by state funds.

Next, early intervention programs must include counseling services for the child and his or her family.

Finally, the related services section must recognize the needs which will be accentuated by the services provided in early intervention. One important aspect of this is the inclusion of rehabilitation counseling to assist in the transition from education to employment and adult life.

Mr. Williams and members of the committee, thank you for your attention to this important issue. If we can be of any further assistance, please do not hesitate to contact us.

AMERICAN REHABILITATION COUNSELING ASSOCIATION
Division of American Association for Counseling and Development
5999 Stevenson Avenue
Alexandria, Virginia 22304

Statement for the Record

Regarding

Reauthorization of Discretionary Grants

Education of All Handicapped Children Act

February 1986

American Rehabilitation Counseling Association (ARCA)

The American Rehabilitation Counseling Association, (ARCA),has a primary mission of helping the profession of rehabilitation counseling to better serve persons with disabilities. In keeping with that mission, ARCA advocates for services and programs which enhance the potential and options available for persons with disabilities. Special Education is just such a service. It can best be viewed as an investment in human potential. Through educational programs designed to tap students' abilities and help them to compensate for weaknesses, special education enables many students with disabilities to prepare for meaningful roles in our society.

ARCA applauds the great strides that continue to be made since the implementation of the landmark legislation, PL 94-142 and its successor, PL 98-199. The major focus of ARCA's recommendations at this time is the area of school to work transition for students with disabilities. The 1983 amendments and this administration's efforts have resulted in significant improvements in transitional services. A substantial problem still exists and will not be remedied without direct action at the federal level. Time will only further complicate an already confused situation. Following is a statement of the issue, some background information and ARCA's recommendation.

Issue

Conflicting federal regulations and outdated state certification laws and regulations prevent most school districts from exercising the option to hire trained rehabilitation counselors to facilitate the transition from school to work for students with disabilities.

Background

The following background information will be presented as a series of frequently asked questions and their answers.

1) Briefly, what is the profession of rehabilitation counseling?

Rehabilitation counseling is a counseling profession which helps individuals with disabilities to adjust to their environments and helps environments to accommodate to individual needs. The profession works toward optimal interaction between the individual and the environment. The profession's foundation belief is in the right of all individuals, including those with disabilities, to access all of society's opportunities and benefits. A primary focus is on the right to meaningful employment in settings which afford integration with nondisabled coworkers.

2) What skills does a rehabilitation counselor normally possess?

The dual focus of the profession requires a dual compliment of skills. The professional must first possess the full compliment of counseling skills. In addition, the rehabilitation counselor must acquire additional knowledge and skills in areas including medical, psychosocial and sociological aspects of disability, potential technological adaptation, career development, environmental assessment, job analysis, job restructuring, and various other areas.

3) What level of educational preparation is involved?

Education preparation for rehabilitation counseling is acquired through a 48 credit hour masters degree from an accredited program. Rehabilitation counselor education programs are accredited by the Council on Rehabilitation Education (CORE).

4) Is any federal funding involved in the training of rehabilitation counselors?

Since 1954, Rehabilitation Education programs have received federal funding from the Rehabilitation Services Administration,(RSA), or its predecessors. RSA is a branch of the Office of Special Education and Rehabilitative Services,(OSERS). Many rehabilitation Counselor Education Programs are even housed in University departments of education. Yet, as Special Education has expanded into Transition services, little progress has been made in resolving the barriers which prevent the skills of Rehabilitation Counselor Education graduates from being used directly in this area. In fact federal dollars are being used to duplicate some of these competencies in other professions (eg Special Education personell preparation grants in Transitional Services).

5)In what settings do rehabilitation counselors currently practice?

Their work settings include: hospitals, state vocational rehabilitation agencies, insurance companies, independent living programs, developmental disability agencies, schools, community mental health agencies, supported employment programs, rehabilitation facilities, private rehabilitation companies, and a variety of other settings.

6)Doesn't the state federal Vocational Rehabilitation system provide rehabilitation counselors to serve students in transition?

Yes and no. Some states have school units as part of regular vocational rehabilitation services. Others do not at this time. Also, students with disabilities sometimes may not receive such services until just before their completion of school. Some students may be considered not eligible for services from the state Vocational Rehabilitation agency.

American Rehabilitation Counseling Association (ARCA)

7) What is the major impediment which school systems face in hiring rehabilitation counselors?

In most states, there are strict certification requirements for individuals providing services within the educational system. In many cases, these requirements were developed long before transitional services became part of special education or before students with disabilities had the right to a free and appropriate public education. In most states, only guidance counselors ,social workers, school psychologists, and special education teachers are recognized in as qualified to provide counseling and supportive transition services in the schools.

8) Don't these or other professions already practicing in the schools possess the skills to do rehabilitation counseling?

While there may be some overlap with some of the counseling professions, trained rehabilitation counselors have many unique skills which are very applicable to quality transitional services. Some of these skills were mentioned in response 2 on the previous page.

9) What are some of the possible roles of the school rehabilitation counselor in transitional services?

The roles and duties will likely vary according to the needs and resources of the school system. A small sample is listed below:

-Job placement, job analysis and job modification.
-Consultation with special and vocational education. teachers on the vocational implications of disability.
-Coordination of school, family and community efforts in transition planning.
-Work adjustment counseling.
-Coordination of job support services (eg. job coaches transportation, attendants) during transition phase.
-Referral to adult services agencies.
-Specialized career planning and linkage with post-secondary programs.
-Development and impementation of Individualized Transition Plan which bridges Individualized Education Programs,(IEPs),and Individual Written Rehabilitation Plans, (IWRPs).

10) Wouldn't the cost be prohibitive for states to develop certification regulations for rehabilitation counseling?

No. The profession already has in place 2 national credentialling bodies, the Commission for Rehabilitation Counselor Certification and The National Board for Counselor Certification.

American Rehabilitation Counseling Association (ARCA)

11) Does ARCA feel that rehabilitation counselors are the only qualified providers of transitional services and that school districts should be required to hire rehabilitation counselors?

No. It is ARCA's position that the breadth of skills involved in the profession, as described above, place graduate trained rehabilitation counselors among those most qualified to provide transition services to students with disabilities. ARCA is simply asking that schools be given the option to hire trained rehabilitation counselors rather than categorically denied that choice.

Recommendations

Either a federal initiative or a modification of federal regulations is needed in order to enable individual school districts to exercise their option to hire rehabilitation counselors. States cannot be expected to individually change a situation which resulted from the interaction of federal law and regulation with already existing state regulations.

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ASCA
AMERICAN SCHOOL COUNSELOR ASSOCIATION

POSITION STATEMENT

The School Counselor and The Education of the Handicapped Act

(Adopted 1980)

The adoption of Public Law 94-142, the Education of the Handicapped Act, by the federal government has provided the framework for more appropriate educational programming for exceptional students. Such components of the law as due process, individual educational programming, and least restrictive environment offer opportunities to utilize the counselor's skills for the benefit of this portion of their clientele. It is particularly important that the role of the counselor in these procedures is clearly defined and understood by all concerned.

The purpose of this position statement is to define those role functions that are and are not reasonably within the scope of the counselor's duties in relation to the implementation of Public Law 94-142.

The American School Counselor Association believes that school counselors might reasonably be expected to perform the following functions in the implementation of Public Law 94-142.

1. To assist in the identification of students with handicapping conditions, including the administration of certain initial screening devices.
2. To serve as a member of the multi-disciplinary team for the purpose of defining the most appropriate program for students with handicapping conditions.
3. To prepare such portions of the student's individual educational program as may relate to services to be performed or coordinated by the school counselor.
4. To provide input as to a student's present level of functioning, affective needs, and the appropriateness of certain programs to meet those needs.
5. To provide supportive counseling for the parents of students with handicapping conditions as it relates to the educational objections stated in the individual educational plan.
6. To provide guidance and counseling services to students with handicapping conditions consistent with those provided to students without handicapping conditions.
7. To provide supportive counseling for students with handicapping conditions consistent with the objectives stated in the individual educational plan.
8. To consult with teachers on the affective needs of exceptional students assigned to their classes.
9. To assist in the development and implementation of professional development activities for staff working with exceptional students in self-contained or mainstreamed environments.
10. To serve in a liaison capacity with vocational-technical schools, regional service units and other agencies in matters relating to students with handicapping conditions.

The American School Counselor Association also believes that there are certain responsibilities pertaining to the implementation of Public Law 94-142 that are NOT PRIMARILY those of the school counselor, although, the counselor may be involved to varying degrees in these duties. Practical consideration of local conditions and state regulations must limit the counselor's involvement in the following activities.

1. To serve as the local educational agency's one representative in formal due process procedures related to the placement of or programming for students with handicapping conditions.
2. To prepare individual educational progams for students with handicapping conditions other than those portions related to guidance services.
3. To act as the only source of information concerning the special educational programs of a district.
4. To make decisions concerning the placement or retention of exceptional students.
5. To serve in any supervisory capacity in relation to the implementation of Public Law 94-142.
6. To serve as a member of the multi-disciplinary team reviewing placement referrals for students who are not normally a part of the counselor's case load.

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ASCA is committed to equal opportunity

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April 28, 1986

The Honorable Orin C Hatch
United States Senate
Washington DC 20510

Dear Senator Hatch:

I have just learned of the details of the Education for All Handicapped Children Bill-S 2294. The American Rehabilitation Counseling Association is extremely concerned about this bill which will be coming to the full Labor and Human Resources committee for mark-up in the next few weeks. For your convenience, I have attached a copy of the statement we prepared for the record and sent to Senator Weicker on February 18, 1986.

Without some action on the part of your committee during the upcoming markup of the bill, the current situation will continue to exist indefinitely. There will be continued unnecessary duplication of federal spending in personnel preparation. Most students with disabilities preparing for the transition from school to work will not receive the services of qualified rehabilitation counselors to assist them in making optimal use of their abilities as they prepare for and enter employment.

We suggest the following change at the time of "mark-up" :

Section 602 (a), Definitions: Item (17)- Insert "rehabilitation counseling" after occupational therapy in the list of possible related services.

This one change should go a long way to rectifying the situation described in our attached statement for the record. We have tried to change the regulations only to be told that the list was not "inclusive" and therefore did not exclude the profession of rehabilitation counseling. The fact is that the vast majority of states still perceive that list as all inclusive and therefore deny school districts the choice of hiring rehabilitation counselors--many of whom were trained using federal dollars. Rehabilitation counselors are not generally seen by the states as coming under the general counseling provision already in this section as that is generally construed to include only school counselors and social workers. Please note that graduate training for rehabilitation counselors is generally seen as comparable to those two professions but additionally focused on the special needs of persons with disabilities as they plan and prepare for employment.

Senator Hatch, this situation appears to represent a serious oversight. The federal government has taken the laudable stand of including school to work transition planning and preparation in the discretionary programs. However a profession with the competencies to assist in this task continues to be precluded from serving students with disabilities in the schools. I realize that the profession of rehabilitation counseling has sometimes been confused with the state federal service delivery system as represented by the Rehabilitation Services Agency. I hope that you will take this opportunity to correct this misinformation For your convenience, I have enclosed a copy of a paper prepared by my association to assist you in better understanding the profession of rehabilitation counseling. You will notice that we serve persons with disabilities in many settings and many service delivery systems.

We hope that you will assist us in allowing schools the option of hiring qualified rehabilitation counselors to assist students with disabilities in preparing for transition from school to work. We are convinced that it is the students with disabilities who will be the ultimate benefactors of your action. Please feel free to write or call if I can provide any further information. Thank you for your continued interest and action on behalf of persons with disabilities.

Sincerely,

Edna Mora Szymanski

Edna Mora Szymanski, CRC, NCC
President

Counselors' Roles in P.L. 94-142

[illegible]

[illegible]

OVERVIEW OF P.L. 94-142

[illegible]

Individualized Education Programs (IEP'S)

[illegible]

Least Restrictive Environment

[illegible]

Due Process Procedures

[illegible]

DETAILED ANALYSIS OF THE LAW

[illegible]

1. Free Appropriate Public Education

[illegible]

[illegible] education programming possibilities. Such alternatives may include regular classes, special classes, special schools, home instruction and private facilities. [illegible]

1. Handicapped Children

Handicapped children are defined as those who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically and other health impaired, deaf-blind, multi-handicapped and those with specific learning disabilities. [illegible]

[illegible]

Comment: [illegible]

[illegible]

2. Related Services

[illegible]

Counseling services must be provided by social workers, psychologists, guidance counselors or other qualified personnel. [illegible]

Comment: [illegible]

[illegible]

Although psychologists, social workers and speech therapists may be involved in this activity, as implied in the regulations, it is obvious that the generalist in the school (namely, the counselor) will often deal with the broader areas related to child development and parent understanding.

Another area that will gain counselor attention is that of vocational education. [illegible] Such activities are more appropriate to the counselor by virtue of training and experience.

The provision of recreation (including leisure education) may go by default to the counselor. [illegible]

4. Special Education

Special education is specially designed instruction to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction and instruction in hospitals and institutions. The term also includes vocational education.

Comment: [illegible]

A related service may be necessary for a child to benefit from some form of special education. [illegible]

5. Individual Education Programs (IEP's)

IEP's are written documents for each handicapped child that must include: (a) a statement of the child's present levels of educational performance, (b) a statement of annual goals, including short-term instructional objectives, (c) a statement of the specific special education and related services to be provided and the extent to which there will be participation in regular educational programs, (d) the dates for initiation of services and the duration of the services and (e) appropriate objective criteria, evaluation procedures and schedules for determining whether the short-term instructional objectives have been met.

Meetings to develop the IEP shall have as participants: (a) a representative of the facility, other than the child's teacher, who is qualified to provide or supervise special education, (b) the child's teacher, (c) the child's parent or parents, (d) the child, where appropriate and (e) other individuals as invited by the parent or agency.

[illegible]

Comment: [illegible]

[illegible]

Elementary school participation will be limited until more elementary counselors are employed.

The participation of the guidance counselor in IEP meetings can occur at several levels. The function could be as the general representative of the district, as a substitute for the child's teacher when it is not practical to include several teachers as at the secondary level, or as a resource person who is knowledgeable about the evaluation procedures and results.

The size of the school district, availability of other specialized personnel and the nature of the IEP will be among the several factors that will determine the nature of the participation.

6. Personnel Development

Personnel development must be a part of each annual program plan and include inservice training of general and special education instruction, related services and support personnel, as well as scheduled procedures for acquiring and disseminating information to teachers and administrators who deal with handicapped children.

Public and private institutions of higher education and parent organizations must have an opportunity to develop and review the system of personnel development.

In terms of inservice training, each annual program plan must provide for: (a) an annual needs assessment and (b) the inclusion of inservice personnel development programs.

These inservice training programs will include (1) the use of incentives (released time, payment for participation, salary step credit, etc.), which ensure participation by teachers, (2) the involvement of local staff, and (3) the use of innovative practices.

Further, each annual program plan must (1) describe the process used in determining inservice training needs, (2) identify the areas in which training is needed, and (3) specify the groups requiring training.

Finally, there will be evaluation procedures established to determine the effectiveness of the program plan. [illegible]

Comment: In the early stages of P.L. 94-142 implementation, it is expected that guidance counselors will be the recipients of inservice training, along with other groups. However, it can also be predicted that, in the future, counselors will be frequently called upon to provide inservice training to other staff members.

Guidance counselors, as part of their job functions, have long been called to interpret pupil behavior and

d an adjective.

[illegible]

7. Due Process Procedures

[illegible]

[illegible]

8. Least Restrictive Environment

[illegible]

[illegible]

9. Confidentiality of Information

[illegible]

[illegible]

RECOMMENDATIONS

[illegible]

[illegible]

Costs of Preschool Special Education

W. Steven Barnett

Early Intervention Research Institute

Utah State University

August, 4, 1986

Costs of Preschool Special Education

The national cost of preschool special education will depend on the cost per child and the number of children served. This paper's focus is on the former. It provides the best estimates of cost per child currently available and identifies the most important influences on cost per child.

The best source of estimates for cost per child is still the Rand report (Kakalik, Furry, Thomas, & Carney, 1981) on the costs of special education. The Rand cost estimates are thorough, complete, and meet accepted standards of economic analysis. The sample used in the Rand study adequately represents the ethnic, geographic, and other characteristics of American public schools. The only significant caveats are that the sample of preschool programs was relatively small and that teacher salaries in the sample may have been slightly higher than average.

The Rand study estimates the average cost of preschool special education to be $3,526 per child in the 1977-78 school year. To update that estimate, it is necessary to take into account cost increases since then. This can be done by way of the implicit GNP deflator for government purchases or an index of change in teacher salaries (which are most of the cost of special education). The resulting estimates are $5,960 based on the GNP deflator and $5,850 based on salary increases (through the end of 1985). It would not be correct to use the CPI to adjust the Rand estimate (Cagan & Moore, 1981). That would produce an overestimate of current cost.

The accuracy of those adjusted Rand estimates can be judged by comparison with the few accurate estimates of costs (adjusted for inflation) that have been derived in preschool program research (Barnett, 1986; Barnett & Escobar, 1986). The Perry Preschool program, a successful program of very high quality, cost about $6,100 in current dollars (Barnett, 1985). Preschool special education programs in Toledo (a relatively high-cost location) cost about $7,300 (Weiss & Jurs, 1984). In Sioux City, Iowa, half-day programs cost about $5,800 (Barnett & Pezzino, in press). Although these are only a few randomly selected estimates, they suggest that the adjusted Rand estimates accurately represent current costs.

For a number of reasons, the inflation-adjusted Rand estimate of roughly $5,900 may significantly overestimate the actual cost per child that results from extending service to all handicapped preschoolers. First, the Rand estimate represents current *average* cost. As service expands and schools spread their fixed costs over more preschoolers, marginal cost will decline and will be less than average cost. Second, the Rand estimate reflects the existing mix of handicapping conditions. Historically, a higher percentage of the most expensive handicapping conditions have been eligible for preschool services (blind, deaf, severely multiply handicapped). Moreover, the most expensive handicaps have the lowest prevalence. Thus, as services are expanded a less expensive mix of handicapping conditions will be served. To illustrate, the average cost for one of the lower cost handicaps (speech) is about $4,170; for one of the higher cost (blind) it is about $11,000. Third, there is considerable potential for Congress to influence cost per child as choices regarding type of service can substantially reduce cost. Preschool special education is an area where knowledge is growing quickly and new technology might greatly cut costs without reducing service quality.

It has already been noted that type of handicap can greatly affect cost. So can school-related variables such as geographic region, urban or rural location, and school size. These variables are accounted for in the Rand study and cannot be influenced by public policy. Many other variables that affect cost can be manipulated by policy, however. These are: whether the program is full- or half-day, number of months of service per year (8, 9, or 12), whether transportation is provided, student-teacher ratio, and the number of years of preschool service provided to each child. The average costs based on the Rand report do not reflect the cost-savings available by choosing appropriately with respect to each of these variables. Research suggests that lower cost options can be chosen without significant deterioration in service quality (Casto & Mastropieri, 1986).

A number of recent studies indicate that, by broadening the range of service options considered and recognizing that children who have different handicapping conditions have very different needs, great reductions in cost can be achieved. For example, the INREAL program (Weiss, 1981) provided special education services to children already enrolled in day care and kindergarten programs by having specialists work in those existing classrooms. The cost was less than $500 per year in current dollars (and that cost was quickly repaid through lower rates of special education placement in elementary school). Another example is the Brigham Young University program to teach parents to help their own language-handicapped preschoolers in everyday activities at home. The parent program was more effective than attending a clinic five days a week, and cost only $500 (Barnett, Escobar, & Ravsten, 1986). This compares to the average public school cost for such children of $4,170 per year. Clearly, encouraging the development of low-cost alternatives can have a high pay-off.

Although there are reasons to believe that cost per child could be much lower without significant degradation in quality, the present system provides no incentives to develop low-cost programs. Moreover, very little is known about low-cost alternatives. Congress could provide incentives in two basic ways. First, it could make service money available beyond the realm of public schools. Preschool special education funds could be made available to Head Start and private non-profit and private for-profit preschool providers as well as to public schools much as Title XX funds are now (which has led to significant public school innovation). An alternative would be to provide support directly to families who could then choose a provider. (Family day care providers, the lowest cost providers, are now being trained to provide special education services to preschoolers.) Second, Congress could express its intent that the economic efficacy of alternative preschool special education programs be a research and evaluation priority. The costs and effects of existing programs could be monitored and research initiated to develop low-cost, high-quality alternatives. Otherwise, the nation may end up with a system that has adequate (if not outstanding) quality at high cost, but leaves many handicapped children unserved because of the public's limited willingness to fund preschool programs.

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July 21, 1986

The Honorable Pat Williams
Chairman, Subcommittee on Select Education
United States House of Representatives
A617 H.O.B. Annex 1
Washington, D.C. 20515-6107

Dear Representative Williams:

Seven years ago, on October 11, 1979, it was my distinct pleasure and honor to testify before your committee when it conducted oversight hearings on Public Law 94-142--The Educatin For All Handicapped Children Act. The singular thrust of my testimony, and a major portion of that of other witnesses, was that the guarantees and benefits of P.L. 94-142 should be extended downward in age to cover handicapped/developmentally delayed children and children at-risk of delay from birth/identification until the age of entry into the public school system of any given state.

The need and importance of such an initiative have not changed since that time. The Senate's recent passage of S. 2294 gives positive and current recognition to what needs to be done. It is my understanding that you will hold hearings this and next week to determine what course of action should be taken by the House. Whether exactly as S. 2294 or by even better legislation, one thing is clear, the handicapped/developmentally delayed infants of this great Nation require strong, timely, comprehensive legislation that has strong fiscal support from the Federal level. Nothing less will make up for this long overdue action.

Because my testimony seven years ago is just as relevant today, I am submitting it along with this letter. I will simply make some brief updating comments which make my earlier comments even more appropriate and germane.

...The enrollment of Austin's Infant-Parent Training Center which so ably served my son has grown by over 20% each of the past four years.

...As a result of initiatives covered in my earlier testimony, in 1981 the Texas Legislature passed S.B. 630, Early Childhood Intervention Legislation, which ensures statewide availability of services for handicapped/developmentally delayed children and children at-risk from birth/identification to age three.

...Of equal importance is the fact that the Texas Legislature is appropriating $9.8 million per year to assist local programs in their efforts. That fiscal support amounts to 40% of our local program's budget and is what has allowed for the annual growth rate of over 20% per year--not to mention the better quality of services.

...Local city and county recognition and support for infant programs has continued to grow.

...A major and highly significant change in the Texas legislative model occurred between the initial initiative in 1979 and the enactment into law in 1981. The law as passed is governed and administered by a five member interagency Early Childhood Intervention Council. Representatives are from the Departments of Health, Mental Health and Mental Retardation, and Human Services; the Texas Education Agency; and a public member appointed by the Governor.

...The Texas model has worked, has stayed cost effective, has brought about unity of effort, and most importantly has brought comprehensive services to every corner of this huge and diverse State. In summary, the requirements spelled out in S. 2294 are nearly identical to the Texas model. Unless very clearly for the betterment of services to children, I would suggest that there is little room for positive change unless it is in the area of raising the level of fiscal support.

...Quoting from a comment by Representative Stack in the earlier hearings, "...not only trying to get Federal funding, and Colonel, you made the point very well, but State funding as well. We have to try to wake up our State legislatures that we need funds for the types of programs we are dealing with here today." The Texas Legislature is not only awake, but it has been most responsive. Many other State Legislatures have also acted. Now is the time for strong Federal support of State initiatives.

I would also like to update you on "...the blond haired, blue eyed, three-year-old little boy..." who in 1979 was "...functioning at the same level as most normal children". Our nine-year-old son Donnie will soon enter the fourth grade in his neighborhood school. He is on grade level in all of his academic subjects. He is a near perfect speller, and in the words of his teacher "is a role model for his 'normal' classmates". In a recent public statement I said that he loves travel, his church, and the circus. And with great pride I still know when I quote from my earlier testimony that--"I have not doubt that, God willing, he will continue to mature and learn to the point that he will be a productive citizen."

Yes, without question, early childhood intervention for children with special needs works and is highly cost effective.

Most sincerely and respectfully,

Don F. Rettberg
Colonel, USAF (Ret)
4002 Sidehill Path
Austin, Texas 78731

Encl.

TESTIMONY

on

HANDICAPPED INFANTS (AGES 0 TO 3)
EDUCATION FOR ALL HANDICAPPED CHILDREN ACT OF 1975
(PUBLIC LAW 94-142)

to

THE UNITED STATES HOUSE OF REPRESENTATIVES'
SUBCOMMITTEE ON SELECT EDUCATION

by

COLONEL DON F. RETTBERG, OCTOBER 11, 1979

Mr. Chairman, members of the Subcommittee, I am Colonel Don Rettberg from Bergstrom Air Force Base, located just outside of Austin, Texas. I appreciate this opportunity to bring you a most important recommendation, however, my words are not the critical element needed for change. It is your action that can, and hopefully will, provide new opportunities for today's and tomorrow's handicapped infants.

Picture in your mind's eye a blond haired, blue eyed, three-year-old little boy -- strong of body, in good health, but with 47 chromosomes in every cell in his body -- not 46 chromosomes as you and I have. Twenty years ago this child would have been called a mongolian idiot, ten years ago he would have been called a mongoloid, but today his handicapping condition is called Down's Syndrome. The labels, though much more palatable now, are also not important; but as the labels have changed, so have the probabilities for such a handicapped child to achieve a meaningful and productive life. As parents we thank God that this little boy, our son Don Jr., was born in this new and enlightened era. We see the positive aspects of infant intervention every day; and while we have had help, it could have been much better.

For the past 15 months parents of handicapped infants in Austin have worked hard to save an infant-parent training center that was started six years ago with the help of time-limited federal grants. We have talked to all levels of government and pointed out the long-term savings and benefits for developmentally delayed children, ages zero to three. City, county, and state officials have all responded in varying degrees to our requests for better, more stable programs, however, the required degree of stability and nationwide benefit can only come from here -- in our Nation's capitol.

Our central Texas example is in some ways a success story, but success -- like failure -- is always relative. As you will see, we had and still do have problems, but remember that these same problems are multiplied a hundredfold in thousands of nonmetropolitan areas throughout Texas and the Nation where there is no assistance at all. Countless children from these areas are doomed to the permanency of life in an institution -- and only because parents and teachers are not given the framework from which to administer proper therapeutic training at an early enough age. It is for this reason that the two words -- oversight hearings -- can have a special meaning to today's and tomorrow's handicapped infants.

The request that I bring before you today is extremely simple and was presented earlier to the Senate's Subcommittee on the Handicapped. The recommendation is based on the same principle that directs federal support to all other special education and is first found in the title of Public Law 94-142 -- "Education for All Handicapped Children Act of 1975." It is again found in the intent of the Act that -- "assures all handicapped children the right to a free and appropriate public education." The key words in both references are -- all children -- not just those who are three or older. The request, therefore, is this -- that this Congress initiate amending legislation to lower all age references in Public Law 94-142 from the currently stated three to zero. If you will keep this concept in mind, I feel sure that you will see how it could affect every future handicapped child throughout the Nation.

Let me give you a short synopsis of why we propose what we do. Our parents' group actions started 15 months ago when 45 children were to be removed from our local infant-parent training center due to a lack of funds. Responsive city and county officials provided emergency supplemental funding with an end result that the level has been maintained at 120 children. Inflation, however, has at the same time eroded quality from the program.

Our search for more funding stability and increases to cover unserved children led us to seek a more lasting, broader-based solution. The obvious starting point became state and federal laws that govern special education. We found that at both levels the laws are consistent in that they cover only children ages three to 21. In fact, when we asked why a study of special education by the Texas Legislature did not consider lowering the age to zero, we were told that the study had "followed the federal guidelines as spelled out in Public Law 94-142." We subsequently came close to getting the needed changes in Texas law in the last session of the Texas Legislature; however, time ran out before the final bell. As a backup position, a special interim committee was established with a mandate to report back to the next session with appropriate legislation that should establish statewide infant programs under the Texas Education Agency. This initiative and my recommendation to you today have the strong support of over 20,000 members of the Texas Association for Retarded Citizens.

By six brief questions and answers let me specifically address why Public Law 94-142 should be changed so as to cover handicapped children ages zero to three:

#1 - What are the benefits of early intervention and education?

A quote from a noted educator, Dr. Benjamin S. Bloom of the University of Chicago, best addresses this question. Dr. Bloom wrote -- "... in terms of intelligence measured at age 17, from conception to age 4 the individual develops 50% of his mature intelligence, from ages 4 to 8 he develops another 30%, and from ages 8 to 17 the remaining 20%."

#2 - What does the current law say, and how should it be amended?

Public Law 94-142 is very specific and in six places identifies age three as the floor for special education. We recommend that in each instance the age minimum be changed to read zero.

#3 - Why haven't earlier legislative initiatives for special education addressed the age group zero to three?

The field of infant intervention is relatively new and as described by Dr. Alice Hayden, one of the foremost authorities in the field, in the past ten years there has been a virtual knowledge explosion in all areas of infant research. In a nutshell -- legislative initiatives have simply fallen behind in converting research initiatives into working community programs.

#4 - What are the reasons for making the change?

The first reason for placing infant programs under the umbrella of special education laws is the practical need for more stable and expanded funding -- in other words -- money. Using Texas as an example, we find that funding under the Department of Mental Health and Mental Retardation has fallen 19% behind inflation in the past three years -- while at the same time special education funding has outpaced inflation. (see attached chart) Closer to home, we currently have 67 children on a waiting list who will not receive help for from six to eight months, and a recent initiative to eliminate the waiting list with supplemental city funding met with total failure.

A second reason is that the change would create the potential to reach every handicapped child in the Nation -- not just those who happen to live near a metropolitan area. In Texas the statewide capacity is 1,600 -- while an additional 2,300 go unserved. Nearly 60% of the handicapped infant population gets nothing.

A final and equally important reason for making the change is that one agency could better direct and coordinate an individualized education plan from the beginning -- rather than two or more as is the case now.

#5 - What are the fiscal impacts of such a change?

While I cannot address the Nation as a whole, I can tell you that for only three cents of the Texas special education dollar -- that's correct, only three cents on the dollar -- the emphasis can be moved to where it would do the most good. This three cents on the dollar, while minimal, can't be ignored; however, we must not overlook the monetary savings achieved by converting potential taxusers into actual taxpayers. The cost of institutional care exceeds $45 per day, and for each and every person who turns the corner as a result of early intervention, the cost savings, based on a life span of 55, is of the magnitude of $115 saved for each single dollar spent.

#6 - How will this change impact individual states?

While writing Public Law 94-142, Congress did not mandate that individual states establish education programs for children ages three to five; however, it did provide a strong incentive to do so in the form of federal funding support. Changing the age to zero would simply ensure the right of eligibility in accordance with guidelines as established by each state.

I hope that our Texas example of what is, and what could be, has left no doubt in your minds as to the need for change. Public Law 94-142 is a revolutionary piece of legislation that has already done so much for so many. All that we ask for in the case of infants is the chance to reap the elusive benefits available in the earliest critical years. Changing the words "aged three" to "aged zero" in all six places in the law will provide that opportunity.

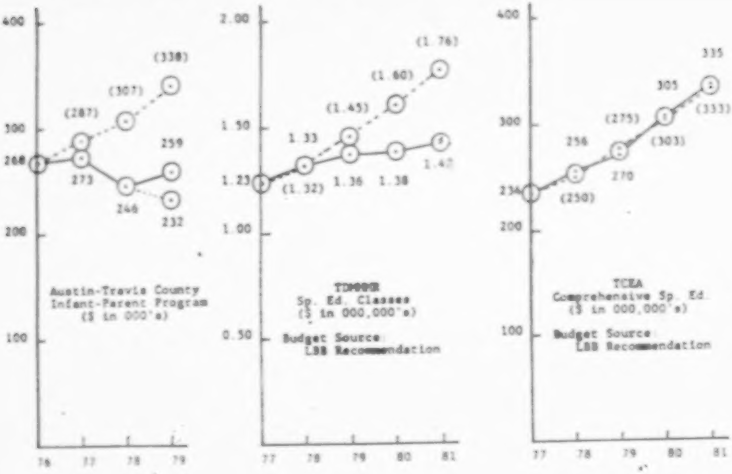
I would like to close on a positive note. The blond haired, blue eyed, three-year-old little boy that I described earlier is functioning at the same level as most normal children. His greatest loves are people and horses. He can recite the Lord's Prayer, most of The Night Before Christmas, and as he salutes the flag -- The Pledge of Allegiance. I have no doubt that, God willing, he will continue to mature and learn to the point that he will be a productive citizen.

We ask you to give every present and future developmentally delayed infant in this Nation the same, if not an even better opportunity, than our son has had. Changing Public Law 94-142 to cover handicapped children from birth will provide that opportunity.

I sincerely appreciate your kind attention and will be glad to anwer any questions.

BUDGET TREND COMPARISONS
PROGRAM/CATEGORY SHOWN vs INFLATION RATE BUDGETS

NOTE: Inflation budgets are based on 7% FY 77-78 and 10% FY 79-81
Amounts shown in ( ) are inflation rate budgets



HOUSE COMMITTEE ON EDUCATION AND LABOR

SELECT EDUCATION COMMITTEE

HEARING ON THE

"EDUCATION OF THE HANDICAPPED AMENDMENTS OF 1986"

Submitted by:

DR. SYLVIA WALKER, DIRECTOR

HOWARD UNIVERSITY CENTER FOR THE STUDY OF HANDICAPPED CHILDREN AND YOUTH

July 29, 1986

INTRODUCTION

Thank you for the opportunity to present written testimony on behalf of the Howard University Center for the Study of Handicapped Children and Youth of which I am the Director.

The Center for the Study of Handicapped Children and Youth (a component of the School of Education at Howard University) is a training, technical assistance, research, and demonstration facility. The primary goal of the Center is to facilitate and enhance the provision of services to the disabled and their families at the local, regional and national levels. The above goal is being achieved through the following activities: research; rehabilitation outreach services; consumer involvement; technical support to families of the disabled; pre-and inservice teacher training; consultation; and information dissemination.

Special projects and activities now in progress include:

1. Competency Based Training Program for Teachers of Severely Handicapped Children and Youth;
2. Howard University Model to Improve Rehabilitation Services for Minority Populations with Handicapping Conditions;
3. Supportive Activities conducted by the Parent Advisory Committee of the Center for the Study of Handicapped Children and Youth; and
4. The Howard University Rehabilitation Model to Assist Homeless and Handicapped Women.

We, therefore, are excited about the prospect of being able to share our views on S. 2294, the Education of the Handicapped Amendments of 1986.

OBSERVATIONS ON S. 2294

As you are quite aware, from birth the individual is faced with ever increasing demands relative to cognitive, linguistic and psychosocial functioning. Mastery of such tasks is especially difficult for the child with congenital or acquired impairments. In spite of the compounding effects of sensory deprivation, physical disability, limited intellectual funtioning and/or emotional complications, it is recognized that all children, no matter how severely handicapped, can profit from early intervention and competent educational programming. Authorities such as Hener, Jordon, and Shearer have documented the benefits of early intervention for handicapped children (Heber and Garber, 1975; Jordon and Dailey, 1975; and Shearer and Shearer, 1976). Other authorities such as Goodson and Hess, Adams, Levenstein, Hewett and Robinson have documented the benefits of parental involvement in the education of their children (Goodson and Hess, 1975; Adams, 1976; Levenstein, 1978; Hewett et. al., 1978; and Robinson and Choper, 1979).

PL 94-142 assured quality education for all handicapped children. In order for early education programs to meet their mandate and fulfill the purpose of PL 94-142, however, it is essential that educational support be provided as early as possible. It is my belief that S. 2294 will help meet that need.

S. 2294, as passed by the Senate would permit state and local agencies to administer the programs and services within local areas and provide flexibility to meet the unique needs within specific areas of the country. The provisions which are especially beneficial are the provisions to:

1. promote the development of formal interagency agreements for service for handicapped infants:

2. assist the state agencies in the development and approval of comprehensive early childhood plans

3. insure that the application for assistances is coordinated with grants awarded in the state under section 627; and

4. disseminate information regarding early intervention.

As previously mentioned, the right of all handicapped children to an appropriate, free, publicly supported education in the least restrictive environment has been guaranteed by the passage of Public Law 94-142. Mandates put forth in the law assure special education and related services which address the unique needs of all children with handicapping conditions. The major provisions of this landmark legislation (free appropriate education, individualized education, least restrictive environment, nondiscriminatory testing and due process) together serve to foster individuality and cultural diversity. The proposed legislation is especially beneficial for young handicapped children and for minority handicapped children since previous legislation has not fully addressed the needs of these special groups.

With regard to pre-school handicapped children, Section 602 (A)(1) would amend S. 2294 to extend the age category of children covered under present law from 3 to 5 years to include infants from birth to 2 years old. The new term "developmentally delayed children" would also be used to replace the terms now used to label disabled children.

With regard to minority handicapped children, it should be noted that legal regulations and guarantees have not automatically eliminated abuses and practices which negatively impact on the quality of education for minority handicapped children. Despite prior legislative mandates, large numbers of Black and other handicapped-minority children are still inadequately serviced (Sadler, Dabney, Chaney and Orange, 1981). Many such children continue to be victims of biased assessment/segregation and benign neglect (Chaney and Sadler, 1981).

Our center at Howard University, which has vast national experience with minority groups, believe that provisions contained in the proposed legislation, S. 2261, are especially relevant since since disproportionate numbers of these children have been identified as handicapped. Thus, the implementation of the proposed legislation will carry with it many positive implications for the psychosocial and cognitive needs of handicapped minority children.

In conclusion, provisions in the bill to provide for more comprehensive services, for greater support through networking and collaboration, and for careful, consistent monitoring of programs by administrative officials have the potential to improve services to the handicapped citizens of our nation ten-fold. We, at Howard, are anxious and prepared to work cooperatively with designated entities to help facilitate these proposed changes nationwide.